Transcript for March 1, 2000 Meeting

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HEALTH CARE FINANCING ADMINISTRATION

Medicare Coverage Advisory Committee
Executive Committee Meeting

March 1, 2000

Health Care Financing Administration
Main Auditorium
7500 Security Boulevard
Baltimore, Maryland 21244

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Vice-Chairperson: Robert H. Brook, M.D.

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Hugh F. Hill, III, M.D., J.D.
Jeffrey L. Kang, M.D., M.P.H.
Consumer Representative:
Linda A. Bergthold, Ph.D.
Industry Representative:
Randel E. Richner, M.P.H.
Executive Secretary:
Sharon K. Lappalainen

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PANEL PROCEEDINGS

(The Executive committee meeting was called to order at 8:11 a.m., Wednesday, March 1, 2000)

DR. SOX: I'd like to welcome everybody to this meeting of the Executive Committee of the MCAC. The purpose of this meeting is to discuss the recommendations of the subcommittee that developed recommendations for all principles and procedures for the panels, and we'll be hearing from a number of representatives of the public today as well as from HCFA as well as from the subcommittee.

We're going to start off by introducing the members of the Executive Committee who have made it already. And I'll start on this side, and hopefully people will show up before we get around to the other side.

Randel, will you introduce yourself and say where you're from.

MS. RICHNER: Randel Richner, Boston Scientific, industry representative.

DR. BERGTHOLD: I'm Linda Bergthold, and I'm the consumer representative.

DR. MURRAY: I'm Bob Murray from the

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Laboratory and Diagnostic Services panel.

DR. HOLOHAN: Tom Holohan, Chief of Patient Care Services, VA, headquartered in Washington.

DR. HILL: Hugh Hill, HCFA.

DR. SOX: I'm Hal Sox. I'm from Dartmouth Medical School and Chairman of the Executive Committee.

Jeff, will you introduce yourself.

DR. KANG: Hi. Jeff Kang, Health Care Financing Administration. I'll introduce myself later on also. I apologize. I'm a little under the weather here, as you can tell from my voice.

MS. LAPPALAINEN: Hello. I'm Sharon Lappalainen with the Health Care Financing Administration. I'm the Executive Secretary for the panel.

DR. BROOK: Robert Brook from RAND, UCLA.

DR. GARBER: Alan Garber, Department of Veterans Affairs, Stanford University.

DR. DAVIS: Ron Davis from the Henry Ford Health System in Detroit.

DR. PAPATHEOFANIS: Frank Papatheofanis, University of California in

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San Diego.

DR. SMITH: I'm Daisy Alford-Smith. I'm the Director of the Summit County Department of Human Services in Ohio as well as the Chairperson of the DME panel.

DR. FERGUSON: I'm John Ferguson, Chair of the Laboratory and Diagnostic Services panel as a consultant in healthcare.

DR. SOX: Now we're going to hear from

Sharon with some procedural matters.

MS. LAPPALAINEN: Good morning and welcome to the panel, chairperson, the Executive Committee and members of the audience.

The committee is here today to hear reports from its subcommittee and will discuss and consider the levels of evidence and types and presentation of information that it believes should be considered by the medical specialty panels at future MCAC meetings.

For the record, I will read the conflict of interest statement for this panel.

Conflict of interest for the Executive Committee meeting, March 1, 2000.

The following announcement addresses conflict of interest issues associated with this

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meeting and is made part of the record to preclude even the appearance of an impropriety. To determine if any conflict existed, the agency reviewed the submitted agenda and all financial interests reported by the committee participants. The conflict of interest statutes prohibit special government's employees from participating in matters that could affect their or their employer's financial interests.

The agency has determined that all members may participate in the matters before the committee today. With respect to all other participants, we ask in the interest of fairness that all persons making statements or presentations disclose any current or previous financial involvement with any firm whose products or services they may wish to comment upon.

And at this time I'll turn the panel over to Dr. Sox.

DR. SOX: Thank you. First we're going to hear some opening remarks from Dr. Jeffrey Kang, who is Director of the Office of Clinical Standards and Quality.

DR. KANG: Dr. Sox, thanks a lot.

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Given my voice, I actually have some remarks that I really want to make at 10:30, 10:40, and I'm going to ask Hugh to read those for me.

I just want to say in addition to being the director of the office, I am HCFA's chief clinical officer, and coverage is one of several responsibilities that I have. I am greatly appreciative of the efforts of the Medicare Coverage Advisory Committee on coverage decisions.

DR. SOX: Thank you.

DR. HILL: If I can say Jeff's prepared remarks, thank you. Good morning to you all. And on behalf of him, I would welcome you all and indicate that the office of clinical standards and quality are the folks that this committee and through you the other MCAC panels advise. He's had a chance to meet many of you personally, but he wanted to welcome you and the members of the public that are here to the second meeting of the Executive Committee of the Medicare Coverage Advisory Committee.

Jeff wanted me to express our appreciation to all those present for your participation in this process, and on behalf of

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HCFA's administrator Nancy-Ann DeParle, we want to especially thank the members of the committee for their service.

Involvement in the initial phase of anything can be challenging and perhaps even more so when the government makes a change. This seems to be true even when that change is universally applauded as an improvement in the way HCFA fulfills its responsibilities to our beneficiaries and the American public generally.

Since the Medicare program began a little over a third of a century ago, some things have changed, and many have stayed the same. We continue to see our mission as beneficiary focused. While we strive for leadership in improving the health of all Americans, our goal remains assuring access to healthcare for the

Medicare-eligible population as we increase our concern for planning in the access of future beneficiaries as well as today.

We have moved towards working with providers of all types as customers and partners in delivering care in recognition of the continued central role of the care professional in assuring our beneficiaries' health. My

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office, Jeff's office, has important new tools and programs for measuring and improving quality, but our eyes remain firmly fixed on Medicare's original and continued goal, better health.

Let me tell you -- myself as well as Jeff would like to tell you -- although there are those that would say otherwise, making good beneficiary-focused coverage decisions is not a new goal for HCFA. Yes, we've shifted from the role of processor and payer to the role of prudent purchaser. And yes, we are more attuned to projections of future Medicare costs than we were at the program's beginnings, but coverage questions have been with us from the beginning.

Congress gave us some guidance in the original statute. Told us not to pay for anything that wasn't reasonable and necessary. You are, I think, aware of our renewed efforts to define what we think those terms mean. But clearly, unarguably, science should have a role when we decide whether or not something is reasonable or necessary. We think science should have the most important role.

We recognize that the critical examination of the scientific literature is

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complex in every case and difficult in many. That's why we need your very expert help, and we are profoundly grateful for it. Thank you.

DR. SOX: Thank you. The next agenda item is the subcommittee report. I'm going to deliver the subcommittee report, and if I could ask for the first transparency, we can get started.

First let me introduce the members of the subcommittee, Randel Richner, Linda Bergthold, myself, Bob Brook, Alan Garber, and David Eddy was also a participant. Dr. Eddy, because of the extreme press of other businesses, had to resign from the MCAC, but he nonetheless has substantial input into this document.

DR. BERGTHOLD: No, he hasn't.

DR. SOX: I beg your pardon?

DR. HILL: We're still talking.

DR. SOX: Oh. We're still talking?

DR. HILL: We're hoping to keep him involved one way or another.

DR. KANG: He's resigned actually from being a chair of the panel but would like to stay on as a member of the MCAC.

DR. SOX: Wonderful. Thank you for

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that correction. I appreciate that.

So our document has two purposes. The first is to provide general guidance to the panels in the form of suggestions -- general suggestions, not detailed suggestions -- about how to evaluate evidence and focus on two characteristics of the evidence.

The first is is it adequate to draw conclusions? And the second is how big is the benefit of the intervention?

So in fact, we asked these two questions. Is the evidence concerning effectiveness in the Medicare population adequate to draw conclusions about magnitude of the effectiveness relative to other items or services? And then secondly, if the evidence is adequate, how does the magnitude of effectiveness of the new medical item or service compare with that of other available interventions?

Then the second major purpose of our document is to suggest specific procedures that the panels should follow in trying to draw conclusions about the adequacy of the evidence and the magnitude of the effect. And these procedures are drawn from the collected

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experience of the members of the subcommittee in doing this sort of work in other venues.

So the goal basically of our document is to make the evaluation process more predictable for the proponents of technology so they know what's going to happen and can prepare for it and therefore avoid unnecessary delays in getting an effective intervention through the coverage process, to make sure that our panels are consistent from one panel to the other and from one technology to the other, to make our decisions, or rather, our recommendations, more understandable to the proponents of the general public, and finally, to make sure that the panels are accountable both to each other and the Executive Committee for the quality of work that they do, but also more accountable to HCFA and to the public. So the whole notion is to try to make this process more transparent so that both proponents and the public understand the basis for coverage decisions that HCFA would make based on our assessment of the evidence.

So let's turn to the next transparency where we deal with what is probably the most difficult problem, which is deciding whether the
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evidence is adequate. Our statement is that the panels must determine whether the scientific evidence is adequate to draw conclusions about the effectiveness of the intervention in routine clinical use in the population of Medicare beneficiaries.

And that statement really can be broken down into two substatements. The first is is the evidence valid? Do the conclusions really represent what actually happened? And secondly, is the evidence applicable to Medicare beneficiaries, the population of interest? So let's spend some time talking about each one of those.

Now, the first question you have to ask when you're comparing the effects of a new

intervention to an old established intervention is are the two populations of patients that you're using to make that comparison truly comparable so that the only difference between them that might affect the outcomes that you're trying to measure is the intervention itself? So when we ask about bias, we ask whether the study systematically overestimates or underestimates the effect of the intervention because of

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possible bias or other errors in assigning patients to either the intervention group or the controlled group.

An example might help here. Suppose there's a surgical procedure of unknown effectiveness, but pretty risky. It's the sort of thing that you wouldn't do on somebody who was real sick for fear that they would die prematurely as a result of the intervention rather than of the disease for which the intervention is intended.

In an observational study in which you try to compare the outcomes of using this intervention with the previous intervention, which is let's say less dangerous, but possibly less effective as well, the problem would ensue, when the surgeon looks at a patient and says this patient is simply too sick to go through this procedure, so I'm going to assign this patient to the controlled group, it's not going to get the procedure. And through a series of such decisions, you end up with the study population that gets the intervention, who's basically pretty well because they're well enough to get through the procedure safely, and the controlled

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group, which are all the sick patients, who look like they wouldn't be able to get through the procedure.

So a year later when you look at the outcomes, sure enough, the people who got the procedure, many more of them are still alive and functioning well as compared with the controlled

group, but because the two groups are very different in their composition, you can't tell whether it was the intervention that led to them being more healthy after the intervention or whether it was the fact they were healthier before the intervention as a result of assignment on the basis of their ability to survive the procedure. So that's an example of biased allocation of patients to intervention and controlled group that could lead to a very misleading interpretation of the outcomes at one year.

So how do you avoid bias? Well, the best way to avoid bias is simply to allocate patients randomly to the controlled group or to the intervention group. Random allocation eliminates the type of systematic bias that I described in my example, although it's still

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possible that the two groups could be unbalanced because of just the random allocation process, which doesn't necessarily assign people to the two groups in equal numbers if the numbers in the two groups are relatively small.

Now, in an observational nonrandomized study such as the one I described in my example, it's often very difficult to decide whether the results were due to bias or due to the intervention. And so we're advising the panels to be very alert to the possibility of systematic allocation bias and observational studies by considering, first of all, the comprehensiveness of the available data, how the patients were selected to receive the intervention and the extent of disease in intervention and controlled groups.

And it's possible, using statistical methods, to control for the variables that you know about if you've measured them carefully. The big problem is that you can't control for the variables you don't know about. And that's the beauty of the randomized approach is that the intervention and the controlled group are

equivalent, not just for the variables you know
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about, but also for the variables you don't know about. It's a very powerful idea, randomization.

In some cases the panel may decide that it can't draw firm conclusions about the effectiveness of an intervention without randomized trials. And you can see how that might be the case from the example I described. But in some other cases, perhaps many cases, the panel will determine that observational evidence is sufficient to draw conclusions about effectiveness.

When they do that, it's really the panel's obligation to describe potential sources of bias that they perceive and to explain why biased allocation as the result of those factors doesn't account for the results. So in other words, there's a substantial burden of proof on the part of the panel to show that it was really the intervention that made the difference rather than some other difference in the two study populations.

Finally, the subcommittee made, I think, a very strong statement saying that a body of evidence that consisted only of uncontrolled
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studies, whether based on anecdotal evidence, testimonials or case series or disease registries without adequate historical controls, is never adequate. So we really feel strongly there needs to be some form of control even if it's only historical controls.

So let's move on then to the question of external validity basically asking the very simple question, do the results apply to the Medicare population? Do we expect that we will see these results in the Medicare population if they receive the intervention?

For a long time randomized studies tended to deal with populations that did not include the elderly. Part of the reason for that

is that the older people have other diseases that may cause their death before the disease for which the intervention that you're testing is intended. And so it's much better if you get a population of patients who have only the disease that you're trying to evaluate as the potential cause of death. And so as a result, until relatively recently, elderly patients were not included in randomized trials.

For example, there are no women over

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the age of 75 in randomized trials of screening for breast cancer despite the fact that the incidence of breast cancer continues to rise through the 70s.

Now, increasingly, randomized trials are including elderly men and women. However, if elderly men and women are included in those studies only in proportion to their numbers in the population as opposed to a study that's only including elderly people, there may be too few older people in the study to draw firm statistical conclusions about the effect of the intervention.

There's also a concern if the study population is not the same as the general population, the Medicare beneficiaries, then you have to decide that results in a particular subsection of Medicare beneficiaries apply to all Medicare beneficiaries that might eventually receive the intervention.

So we call upon the panel to explain its reasoning in deciding that the findings of a series of studies really apply to all Medicare populations. And in fact, the panel might conclude that they don't, and it would be up to

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HCFA then to decide on coverage based on that conclusion.

Finally, interventions vary from site to site. What works at Johns Hopkins or at Mass General may not work in a community hospital. So the panel has to explain whether the results that

are published are going to apply to all healthcare settings and explain why they think that would be the case.

So far we've talked about how you evaluate the adequacy of the body of evidence. And the issues, again just to repeat them, are, first of all, biased allocation of patients to the intervention group and the controlled group as something that interferes with the ability to draw a conclusion about whether it's the intervention that really made the difference, and secondly, the general applicability of the results to the Medicare population.

So let's now turn to talk about the size of the health effect. And our statement is that evidence from well-designed studies that meet the first criterion -- that is to say adequate evidence -- must establish how the effectiveness of the new intervention compares

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with the effect of established services and medical items.

And we think that we've helped HCFA with its assignment to make coverage decisions by placing both the size of the effect and the direction of the effect as compared with established services or medical items into one of these seven categories. And by the direction of the effect, I mean is it better or is it the same or is it worse?

So one category would be a breakthrough technology. This is something that we all want to see a lot more of, something that causes such a large improvement in healthcare outcomes that it becomes overnight standard of care.

The second category would be more effective. The new intervention improves healthcare outcomes by a definite significant, albeit small, margin as compared with established services or medical items.

The third category would be as effective, but with advantages. So the intervention has the same effect on healthcare

outcomes as established medical services or items, but it has some advantages that would be
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important to some if not all patients, such as convenience, rapiditive effect, fewer side effects and so forth. So some people might prefer it over existing interventions.

Then there's a category called as effective, but with no advantages, an intervention that basically has the same effects on healthcare outcomes as existing services and doesn't have any substantial advantages.

A fifth category is less effective, but with advantages. So it's certainly possible that an intervention could be somewhat less effective than existing alternatives, but it would have some advantages that would be so important to some patients that they might choose it even though it might not have the same effect on their health status as existing interventions.

The sixth category is less effective with no advantages. The intervention is less effective than established alternatives, but more effective than doing nothing, and doesn't have any significant advantages.

The last category is not effective. The intervention has no effect or has deleterious effects on healthcare outcomes when compared with
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doing nothing, such as treatment with placebo or patient management without the use of a diagnostic test in the case of a diagnostic test.

So let's then move on from two principles by which the panels can hopefully provide consistent, understandable advice to HCFA about the quality of the evidence and the magnitude of the effect on healthcare outcomes.

Now we're going to get into operational procedures, how the subcommittee feels the panel should operate in order to provide consistent results from panel to panel and from intervention to intervention.

And the first basic principle is that

the panel must explain its conclusions in writing. And this requirement is clearly aimed at trying to improve the transparency of the process and the accountability to the public as well as to the proponents of the technology.

We've also put it in the hands of the panel chair to be responsible for writing the explanation of the panel's conclusions.

The next procedural recommendation has to do with structuring the evidence so that the panels can function effectively. So we recommend

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that the panels should receive well-organized, high-quality background information before they begin their deliberations about the adequacy of the evidence and the size of the effect. And we recommend that the evidence should be summarized in a report, which we call an evidence report, not simply presented as a collection of data or primary studies. And there's ample precedent for this in the technology evaluation efforts of many other organizations.

So our basic principle is the integrity of the coverage decision process begins with complete critical evaluation of the literature. And we feel that the standard for HCFA should be the best that's out there in other settings, such as the private sector where Blue Cross Blue Shield has a long track record of doing evaluations of the evidence and making coverage decisions in what is a process that's both efficient and I think highly regarded by professional organizations such as the ACP-ASIM and by other federally sponsored panels. The Agency for Health Research and Quality has a series of evidence-based practice centers in various universities, and I think there are a

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couple of private settings around the country, and they provide technical support for the U.S. Preventive Services Task Force on which I serve.

Now, evaluating the evidence carefully and providing a balanced, well-organized report

of it to the panels is a task that inevitably is going to take some time. It's the opinion of the subcommittee that it should be possible to do these reports in six months or less. Those of you who are experienced in doing this work know that that's fast for doing an adequate evidence report, but we think that HCFA should meet that standard.

The next procedural recommendation is basically that members of the panel should be actively involved in the process of reviewing the evidence, and that's based on quite a lot of experience with other health technology programs.

So for example, we think that the chair of the panel and perhaps others -- but certainly the chair -- should work with HCFA to establish which are the most important questions that the evidence report should address, and then ultimately the panel must answer as part of its

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deliberations.

Secondly, we feel that several members of the panel should be active participants in designing the evidence review and preparing the evidence report that the panel will consider. And that's based in part on what we feel is the need to have real expertise on the panel on the topic in question. And the best way to get that expertise is to participate in the design of the evidence review and the writing of the report.

Finally, we feel that it's very important that each evidence report be given an extremely careful review. We expect that all members of the panel will read the report very carefully, but we also recommend that one or two members of the group be assigned to be what are called primary reviewers, and we expect those people to really dig into that report, do their best to find any potential problems with the report so that the panel will know that the report has been given sort of the ultimate in very close scrutiny.

Finally, we recommend that there be expert review of the evidence report. To ensure that the evidence report is complete and free
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from bias, the Executive Committee recommends expert review of the evidence reports. This is going to mean in general subjecting the reports to external review. And the purpose of that is to assure everybody, the public, the proponents and the panel, that the evidence report is complete and that it's fair.

That external review should take place before the panels meet, and the evidence report as well as the comments of expert reviewers will be part of the public record of the panel's deliberations. We envision a relatively small number of expert reviewers, perhaps a half dozen, and we will require them to complete their review in a timely fashion, within a month.

Now, the last transparency is not part of our report, but it's based on what you could read in the report as a possible time line for a typical MCAC evaluation. So times zero is the time that HCFA decides to go to MCAC for an opinion about the adequacy of the evidence. Then in the first month HCFA and the panel chair would decide on what are the key questions that the panel needs to address and what are the key requirements of the evidence report. In
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addition, HCFA would decide who would do the evidence report.

Month two to seven would represent the time during which the evidence report would be prepared. And again, it might not be month two to seven. It might be month two to five if the topic was one that led itself to a more speedy conclusion of the review of the evidence.

In month eight the report is out for external review. It's out to members of the panel for review. And at the end of that month there's a meeting of the panel that leads to a report to the Executive Committee. And certainly

in the ideal world, the timing of the Executive Committee meetings would be closely tied to panel meetings, so the Executive Committee could sign off on the recommendations of the panel within a month after the completion of the panel meeting. And then it will be up to HCFA to decide on its own time schedule about coverage policy.

So that concludes the report of the subcommittee. And I think it would be good now for members of the subcommittee to say anything that they wish about my report to be sure that it reflects the views of the members of the

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subcommittee.

So would anybody on the subcommittee like to comment at this point on my review?

MS. RICHNER: I have something.

DR. SOX: Randel, please.

MS. RICHNER: I actually wrote something last night. I wanted to write them all down so that I didn't forget anything. So excuse me while I load up here to get something. If anybody else has anything to say -- I didn't know that this was my time to talk.

DR. SOX: Randel, is it okay if John makes a few remarks?

MS. RICHNER: Sure.

DR. FERGUSON: Just a few. First of all, I think that this is a very nice road map. It's an idealistic road map in my view. And I guess my overall view is although I think that this is something that we all might like to shoot for, that the end result following this totally might tie the process so that it wouldn't work, and I would not like to see that happen.

A couple of specifics. Point one on the adequacy of the evidence.

DR. SOX: John, actually, if you don't

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mind, I think I'm going to interrupt you. We're going to have an opportunity later on in the morning to present our concerns about the report. I think maybe it would be better to do

that later and just have the members of the subcommittee comment on whether I have given the report as they think it is. Is that okay?

DR. FERGUSON: Sure. You meant from the members of the subcommittee?

DR. SOX: Yes.

DR. FERGUSON: Excuse me.

DR. SOX: If you wouldn't mind holding it.

DR. FERGUSON: That's fine.

DR. SOX: Has that given you enough time to get your thing up on the computer?

MS. RICHNER: Once again, I'm sorry to have to do it this way, but I decided to write this on the computer last night, so I didn't have any way to print it.

DR. KANG: We can print it for you.

MS. RICHNER: That's okay. I'll just read it.

In my work to date with MCAC, I have attempted to bring views on the impact of our

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coverage and process recommendations on the industry, on technology development and innovation, and first and most importantly, of the impact of these recommendations on patient access to new technology.

My views are derived from years of practical experience and applied research from being a nephrology transplant nurse, public health research background, including health economics -- now comes research for the pharmaceutical industry -- and most recently, as the vice president of a large manufacturer of minimally invasive technology.

I've always considered myself one who comes from a scientific and clinical perspective and passionate about what is important for the patient. Having said this, I am certain that no matter what I say, it will not be to the liking of at least one if not several of the constituencies represented here today.

While I was invited to participate in

the subcommittee who has drafted this document, I can say that I am not completely satisfied with the final output of this draft. First, I was particularly concerned with the tone, which

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implied a lack of flexibility in reviewing and assessing the information that is available for technology assessments. I feel that overall the document assumes that new technology information is innately flawed, or another way of saying it, that all technology is guilty until proven innocent and that it is HCFA's responsibility to protect the public.

Second, we do not take into account the availability and rigor of evidence that is available over time for a technology. Depending upon when the technology is referred to MCAC, the life cycle of the technology can have a profound impact on the level and the types of evidence to be reviewed.

Third, our primary task was to describe a process for which the panels could make efficient decisions. I felt the draft was never clear on the who, what and when directions for the panels. I also was concerned that we have added on time and many additional reviewers that would make the overall process arduous for any technology to overcome.

However, I must strongly support that we, the industry -- and I assume that we're all

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the industry in some ways -- have a responsibility to the patient to ensure that the technologies we develop and expect to be covered and paid for will ultimately produce some additional benefit to the Medicare patient. This should be expected and demanded by consumers of healthcare services and products.

Finally, I feel that HCFA should have provided MCAC more guidance for the Executive Committee on content and process. I feel that the lack of published guidelines could have provided clearer guidance on criteria for which

the technology should be assessed. They've essentially left it de facto to the committee.

I'm very committed to the MCAC process. We have an incredible resource of dedicated, highly talented individuals from which we can freely draw and use their expertise for a technology assessment process that is workable, doable, predictable and fair.

The committee should have had instruction on the goal of coverage evaluations in a divided, fragmented coverage and payment system that no one can possibly understand who is not intimately involved with the inner workings

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of HCFA. I even wonder if those inside HCFA really understand how one system affects another. It's very important.

As a quick example, how many times have I heard recently from very educated individuals, why can't we simply get them, HCFA, to increase the DRG payment to cover the new technology? J&J did it with stents. I hear that one all the time.

In conclusion, all the dialogue has been particularly useful to move this to the point where I believe we can now successfully design a process and criteria that will work for fair technology assessments. With some open and frank discussions I expect we'll have today, I hope that we can enable a definitive coverage process for promising therapies and technologies. Thank you.

DR. SOX: Thank you very much.

Would any other member of the subcommittee wish to make any remarks?

Well, since there are no further remarks from the subcommittee, it's now time for us to go into open public session. And let me just briefly lay out the ground rules. We have

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nine people.

DR. BERGTHOLD: I'd just like to say one thing for the record.

DR. SOX: Thank you very much.
DR. BERGTHOLD: I just wanted to comment on the process of the subcommittee for those of you who didn't have the opportunity to be involved, including people here around the table, and that is that Hal as chair was very open to all kinds of our concerns about nuance, word and tone, and I believe this went through at least a dozen drafts and iterate of drafts trying to be sure that the tone was clear.
And so while some may think that this looks negative, I think it is incumbent upon everyone, not only here, but in the audience, to really carefully read this document. Almost every word was discussed and talked about at great length so that the tone would be clearly that while there's a gold standard for evidence, we understood, all of us, that not every new technology will meet that standard.
So I just wanted to make that clear, that we had this level of discussion at the subcommittee level, and I wanted to thank Hal for
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being very receptive and open to everybody's comments. Thank you.
DR. SOX: Thank you very much.
Any other comments before we move on?
In that case we'll go into open public session. The plan is to have five speakers in the next hour, then take a 20-minute break, and then come back for the last four speakers, then move on to the HCFA presentation at approximately a quarter to 11:00.
So five divided into 60 goes 12 minutes per speaker. Excuse me.
Could you approach the mic if you have to make a comment.
DR. WEISENTHAL: My name is Larry Weisenthal, and I just have a protest concerning the allocation of time to the speakers. I noticed that your five speakers for the first 60 minutes have 12 minutes a piece, and that leaves four speakers in 20 minutes for five minutes a

piece. So the first speakers get 12 minutes. The second speakers get five minutes.

I paid $900 of my own money to fly from California and miss two days of work, and I was told in advance I'd have ten minutes. I can say

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it in ten minutes, but I'd really like to have 12.

DR. SOX: Thank you very much. Everybody's going to have the same amount of time. Let's see. We've got basically an hour and -- I think what we'll basically say is ten minutes per speaker, which I guess is what you were led to expect, and we'll just let the time fall where it may.

So I'm going to ask you to stop at ten minutes, and I will be impolite and tell you to sit down if you try to go over, just so you understand that's the way I am. And I'll raise my hand with about a minute to go to give you a chance to wrap up.

So let's start with Guido Tricot, who is Director of the Myeloma Transplant Center at the University of Arkansas. Welcome.

DR. TRICOT: Thank you very much for giving me the time to bring up a few issues. My name is Guido Tricot. I'm the director of the myeloma program at the University of Arkansas.

The first issue I would like to bring up is the age issue. Although we assume that Medicare is mainly for patients over the age of

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65, when we reviewed the records of patients who had transplants for myeloma, approximately one-third of the patients were under the age of 65. That's one issue.

The second issue about age is that most of the reasons why age has become a problem --

MS. LAPPALAINEN: Could you bring the mic closer to you? It's wireless, so you can pick it up, if you'd like.

DR. TRICOT: -- why age has become a problem is because of the comorbid conditions

that the patients may have. And in most studies there are sufficient exclusion criteria to deal with the comorbid conditions. And rather than making age an issue, because we all know that there is basically no difference between a patient who is 64 years and 11 months and somebody who is 65 years, and that there's a difference between calendar age and biologic age, I think exclusion criteria rather than age itself should be the main thing to exclude comorbid conditions.

A second point that I would like to bring up is that in the explanation of panel's conclusion, the panel chair is responsible for

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writing the explanation of the panel's conclusion. We need to make sure that there are mechanisms in place that the report is a reflection of the whole group of the panel and not necessarily mainly a reflection of what the chair's vision is.

A third point is the external review by experts. Although it states that this will become part of the public record, we need to make sure that this becomes part of the public record prior to the panel meeting and that there's adequate time to review and comment at the time that the proponents will make the report.

A smaller comment is on the randomized studies. Although we all would like to have many randomized studies all showing the same results and going in the same directions, we also need to be aware of the fact that once there is one randomized study that shows that one treatment is better than the other, it becomes difficult to do further randomized studies. In principle you're only supposed to do randomized studies if as a physician you're not convinced that one treatment is better than the other and that you have no bias toward any of the treatment modalities.

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There's also a problem with referral patterns. We at the University of Arkansas have

tried to do randomized studies, but the patients that are coming to our institution come from everywhere, and they come because they want a certain procedure done, and we have never been able to do randomized studies because of that.

And the last point I would like to bring up is that there is a tremendous time lapse between initiation of the process and the point in time the proponents are convinced that what is proposed is better than what has been available before and the ultimate approval. And it's going to be at least nine months, and probably more likely, 12 months or more. And I think there should be a mechanism in place that provides temporary approvals in between this 12-month lapse and that a committee of experts can be gathered to give temporary approvals until the final decision by HCFA is made.

I think those are my main concerns. Thank you very much for giving me this time.

DR. SOX: I should remind the members of the Executive Committee that we're going to have about an hour to ask questions of the people

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who are going to speak. So take notes and be ready to ask some questions during the hour that will be reserved for discussion with them.

With that, we'll move on to Richard Justman, who is medical director of United Healthcare and the American Association of Health Plans.

DR. JUSTMAN: Thank you. Good morning. My name is Dick Justman, and I do not have any financial connection to technology or device manufacturers. In my current position that would be very difficult.

My name is Dick Justman, and I'm the national medical director of United Health Group.

DR. HILL: Excuse me, Dr. Justman. Would you do the same thing with your microphone? Folks in the back are indicating they can't hear.

DR. JUSTMAN: Is that better?

DR. HILL: Thank you.
DR. JUSTMAN: I'm the national medical director of United Health Group, and I'm here today speaking on behalf of the American Association of Health Plans. AAHP represents more than a thousand health maintenance
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organizations, preferred provider organizations and other similar network-based health delivery systems that provide healthcare to more than 150 million Americans. AAHP member health plans are dedicated to the philosophy that we put patients first by offering them benefit packages offering coordinated comprehensive healthcare.
United Health Group, the company for which I work, has 40 health plans around the United States serving approximately 14 million commercial enrollees in HMO, PPO point of service and exclusive provider organization products. We also have approximately 400,000 Medicare enrollees.
As you may have read recently in the newspapers, United Health Group has recently embarked upon a program which we call care coordination, and this is a model of healthcare coverage which essentially allows physicians and patients to make healthcare decisions with minimal intrusion by the health plan subject only to the limitations of benefit design. However, we feel very strongly that for this endeavor to work, we need to be covering procedures to biases, treatments and drugs that we know
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actually do work.
We strongly endorse a rigorous, evidence-based approach to coverage determinations. We applaud the establishment of the Medicare Coverage Advisory Committee to assist HCFA to evaluate the clinical evidence about the relative effectiveness of new medical devices, services and other technologies.
The report of the Executive Committee working group to be discussed today will promote

systematic and consistent evaluation of the clinical evidence by the panels that we believe should meet the needs of all the stakeholders.

There is compelling evidence, including evidence cited by President Clinton's own advisory commission on consumer protection of quality in the healthcare industry, that Americans do not always receive the best possible healthcare. In many instances they do not receive important healthcare services that they should, and yet in other instances they receive services of uncertain value, and unfortunately in yet other instances they receive services of questionable quality.

Also, too often medical treatments are

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widely disseminated before they have been proven to be effective putting patients potentially at risk of harm, and this also discourages for further research.

Both of these problems, the variation and the use and quality of healthcare services and the proliferation of unproven treatments, illuminate the importance of promoting a delivery care that is based upon robust, scientific evidence.

To give you an example, a recent study showed that between 1987 and 1991, only 21 percent of eligible elderly patients were treated with beta blockers for ischemic heart disease, myocardial infarction and related disorders and that the subsequent mortality rate for those who did receive the treatment was 43 percent lower than for those who did not receive the treatment. This translates into, in that study group, 18,000 potentially avoidable deaths that would not happen because the appropriate treatment was not given.

What is really stunning in this case is that in the words of the American Medical Association, beta blockers are one of the most

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scientifically studied and substantiated medical

therapies. There is a plethora of published evidence about them. The American College of Cardiology and the American Heart Association have brought guidelines and physician statements promoting their use. And despite this and despite voluminous evidence, there are many eligible people who potentially would have benefited from beta blockers who have not received them.

A second problem undermining the quality of care is the proliferation of treatments that have been widely disseminated in the absence of proof that they are effective. In such cases patients may be harmed because they forego a standard proven therapy in favor of a treatment that may be less effective than the standard one.

A most recent example is that of high-dose chemotherapy and bone marrow transplantation for women with breast cancer. An assumption was made many years ago that if women are partially responsive to standard dose chemotherapy, that high-dose chemotherapy coupled with bone marrow or peripheral stem cell rescue would be even more

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effective. Unfortunately at the time this assumption was made, there was little evidence to support this, little robust scientific evidence. And in fact, this became widely disseminated as a treatment that women must have. Well-intentioned advocacy groups promoted its use. Many states actually passed laws mandating coverage for this. And this essentially became a self-fulfilling prophecy.

Women assumed that if states were mandating coverage for this, this must be a preferred and effective treatment. This essentially made it very difficult for women to randomize themselves into controlled trials because women were afraid that if they were randomized into the standard treatment group, they would miss out on treatment that might be effective. So in fact, there was circular

reasoning here.

And as you know, there has been recent published evidence that says that if anything, high-dose chemotherapy bone marrow transplantation is no more effective than standard chemotherapy for women with breast cancer although the morbidity of high-dose

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chemotherapy is substantially greater. So this is a very stunning example of a situation in which a therapy is rapidly proliferated in the absence of scientific evidence, and it is very difficult now to reverse that trend.

Another example of a less life-threatening but equally pervasive disorder has to do with low-back pain. Approximately a year ago in a national news weekly, a device was discussed, which presumably through a heat treatment, reduces significantly diskogenic low-back pain. This was widely reported, and many providers in many regions of the country began to promote this treatment.

At the time that this was done, there was almost no scientific evidence published at all. All the scientific evidence that was available was available on a website.

To make matters worse, there were yet other providers who began to use this device to treat neuropathic pain, for which the FDA indications never existed in the first place. So this is yet another example where in the absence of scientific evidence, there can be rapid proliferation of technology that desperate people

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will try to use.

Health plans have taken a prominent role in promoting evidence-based care. Increasingly, health plans are working with physicians to reduce the variation in practice patterns through the dissemination of chemical profiling tools and processes of care that guide physicians to provide their patients the right care at the right time and in the right setting.

Health plans distribute and encourage the use of evidence-based processes of care by physicians and other healthcare providers. Health plans also provide feedback to physicians about how their treatment practice patterns, including underutilization and overutilization, compared to scientific evidence and also to the practice patterns of their peers. Health plans make scientific coverage determinations based upon the best available evidence. Through these and other activities, health plans actively promote the use of evidence-based care.

Through technology assessment, health plans are working to approve coverage of new treatments supported by medical evidence and to avoid the coverage of treatments for which there

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is no scientific evidence and for which these treatments may actually harm patients. In technology assessment organizations gather and evaluate the scientifically valid evidence available, including, but not limited to, surgical procedures, devices and drugs.

First, they determine whether the evidence demonstrates that the treatment is safe. Second, they evaluate whether or not the evidence demonstrates that the treatment is as effective or more effective than an existing treatment if an existing treatment does exist.

Health plans use this information in determining whether or not the treatment should be a covered service. By implementing a structured method for evaluating new or existing treatments and not covering treatments not proven to be effective, health plans are working to reduce the proliferation of unproven and potentially unsafe treatments.

However, health plans cannot solve this problem alone. We need the help of others within the system, including Medicare, Medicaid providers, researchers and manufacturers. Increasingly, the healthcare community and policy

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makers recognize the importance of promoting evidence-based care and are working to change the current environment.

In addition to health plans, others in the healthcare community understand the importance of promoting and providing evidence-based care, and in order to be valid, the evidence itself must meet certain criteria.

We support very definitely the use of the best possible scientific evidence, and we are aware that randomized controlled trials ideally are the best evidence. We recognize also, however, that those are not always possible, either due to the lack of availability of a control arm, the size of the cohort or other factors. However, we believe very strongly that we must always seek the best scientific evidence that is available and the best methodology available in order to make coverage decisions.

In conclusion, I would like to stress that the first goal of the healthcare system should be to provide quality healthcare services. In our current system too often quality is compromised because the care delivered is not consistent with the best available medical

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evidence.

Health plans are committed to improving quality care through reliance on medical evidence when making coverage determinations, when evaluating new therapies and in communicating with providers. In order to improve the quality for all patients, however, all stakeholders in the healthcare system, not just the health plans, must be actively committed to the process of using evidence-based medicine. Thank you.

DR. SOX: Thank you very much. Just so that the speaker knows when there's one minute to go, I'm going to stand up, which hopefully will catch your eye. Putting up my hand didn't seem to work very well.

Our next speaker is Morgan Downey, Executive Director of the American Obesity

Association.

MR. DOWNEY: Thank you, Mr. Chairman and members. It's a pleasure to be here with you this morning.

My name is Morgan Downey, and I am the Executive Director of the American Obesity Association. This association is about four years old, and it was founded as an adequacy

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organization to promote research, treatment, prevention and intervention in the epidemic the country is going through, obesity.

I'm very pleased to be able to address the complex issues of obesity in the Medicare program with you this morning. For the record, the American Obesity Association is supported by several major companies, including Amgen Hoffman-LaRoche and all pharmaceuticals, Weight Watchers International, in dues from professional and lay members. To the best of my knowledge, no supporter has a specific coverage issue before the Medicare Coverage Advisory Committee at this time.

At the outset I'd like to put our current and immediately foreseeable situation on the record. Over half of the United States population is overweight, and about a quarter is obese measured as their body mass index of over 25 and over 30 respectively. According to 1991 data, the percentages of the Medicare population, with the BMI of over 27.8 percent for males and 27.3 for females, ranged from 23.8 percent for white males to 48.7 percent for black females.

As you well know, obesity is a major

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independent risk factor for conditions such as Type II diabetes, hypertension, heart disease, stroke, several cancers, arthritis, end stage renal disease, gallbladder disease and sleep apnea, to name a few of the 30 or so conditions where associations have been found.

We know that obesity is increasing rapidly in the population. Jeffrey Copeland,

Director of the Centers for Disease Control and Prevention, has likened its spread to that same in infectious diseases. According to a recent article in JAMA in October, between 1991 and 1998, the prevalence of obesity measured as a BMI over 30 among persons age 60 to 69 increased 44.9 percent. The prevalence among persons over 70 increased 28.6 percent. That is a rate of 6.4 percent per year at a BMI level of 30 and four percent a year increase for a person over 70.

We also know that obesity is a major generator of healthcare costs. According to a study of the American Obesity Association commission from the Lewin group last year, the direct healthcare cost of obesity exceeded a hundred billion dollars in 1999. This figure does not include indirect costs or costs spent on

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treating obesity itself. We did not ask for a breakdown by payers, but I think it's fair to assume that the Medicare program plays a significant if not majority component of those costs.

So it's not without substantial justification that obesity is now listed as one of the nation's ten leading health indicators, as announced a few weeks ago by the surgeon general.

We concede, therefore, that more and more Americans are becoming obese, which will dramatically increase their risk for diseases, which Medicare will pay for. These people will come into the Medicare program, both as they age, and also as they become eligible for disability under Social Security disability procedures.

The standards for the evaluation of obesity under Social Security is currently undergoing some changes, but we expect that the current number of 137,000 persons who receive Social Security disability under their obesity listing will continue to increase. And as you know, after two years on disability, these individuals start receiving healthcare coverage

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under the Medicare program.

Our interests today are twofold. First, we propose that the committee consider when evaluating new medical profits, be they laboratory tests, diagnostic procedures, preventative intervention or treatment, that a large portion, a quarter to a half of the Medicare population, is overweight or obese.

Questions might be asked were the studies in support of the procedures conducted in a representative sample of the current population by weight? Can Medicare beneficiaries who are obese access the new technologies?

As an example, there are recent studies showing, for example, that obese women receive pap smears and mammograms with less frequency than do nonobese women.

Last fall the representative of HCFA, speaking at a conference we had on public policy implications of obesity, indicated that the bone marrow transplantation protocols in this country exclude persons with obesity without medical justification.

Second, we propose that the committee begin the process of clarifying Medicare coverage
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of obesity. Paragraph 3526 of the coverage manual states, quote, obesity itself cannot be considered an illness. The immediate cause is a caloric intake, which is consistent with a higher than caloric output. Program commitment may not be made for the treatment of obesity alone since this treatment is not reasonable and necessary for the diagnosis and treatment of an illness or injury. Yet under paragraph 3540, obesity surgery, bariatric surgery is covered if medically appropriate and necessary to correct an illness caused or aggravated by obesity.

Clearly these two paragraphs are inconsistent. If obesity cannot be considered an illness, the surgery to correct it can't be covered. On the other hand, as a reduction of

weight can correct an illness or injury aggravated by obesity, what possible justification is there for covering exclusively the most drastic and life-threatening intervention when other equally effective and less risky treatments are available? Clearly 3526 of the coverage manual is wrong and should be considered an embarrassment to the Health Care Financing Administration.

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Illness is synonymous with disease. Virtually every medical and scientific definition define diseases as, for example, does Stedman's medical dictionary, which is, one, an interruption, cessation or disorder of body functions, systems or organs, or two, a disease entity characterized by at least two of these criteria; one, recognized etiologic agent or agents, two, an identifiable group of signs and symptoms, three, consistent anatomical alterations. Clearly obesity means all three of these criteria.

Any analysis of the definitions of illness and injury disorder will demonstrate that obesity is considered an illness by the vast weight of modern, scientific and medical understanding. Therefore, we'd like to suggest two issues for your consideration.

First, given the increase in the overall Medicare population which is obese and the increases in medical technology, we want to be sure that all such advances are available to the obese Medicare population. Therefore, AOA suggests that all future subjects for Medicare coverage determinations be evaluated with this

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population in mind.

Second, we suggest the committee establish a subcommittee or working group to revise the current and incorrect coverage manual paragraph 3526. There are many professional guidelines for the treatment of obesity in adults including that developed two years ago by the

National Institutes of Health, which relies on literally hundreds of randomized controlled clinical trials and other studies which would meet the criteria earlier elucidated by the chairman regarding the considerations of this committee.

The American Obesity Association would be pleased to provide whatever assistance or support would be helpful to the committee in these undertakings. Thank you.

DR. SOX: Thank you very much. Our next speaker is Donald Baim.

DR. KANG: Hal?

DR. SOX: Jeff?

DR. KANG: Mr. Downey, on your second issue, procedurally -- I think you got our April notice last year -- you really need to submit a coverage decision internally. MCAC gets only a

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very small subset referred to by HCFA. This is actually the first time I'm aware of that coverage manual issue, and we'd be happy to look at it, but maybe we can talk about that off line how to get that done.

MR. DOWNEY: Okay.

DR. SOX: Thank you very much.

Our next speaker is Dr. Donald Baim, Chief of the Interventional Cardiology Section at the Beth Israel Deaconess Hospital, and he's speaking today on behalf of the Health Industry Manufacturers Association.

DR. BAIM: Thanks. It's my pleasure to be down here. HIMA asked me to speak about some of the real world applicability of technology innovation and adoption in the interventional cardiology area and specifically as it pertains to the coverage decisions by this group.

Can I see the first overhead, please. I think we all share common goals in terms of encouraging industry to develop newer devices and device improvements and facilitate the rapid adoption of safe and effective new diagnostic and therapeutic technologies in healthcare to improve

the well-being of our population. We more than
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anyone endorse the use of robust-data-driven approaches and avoiding technologies that are less effective. And I'll talk a little bit about where the FDA process has gone in interventional cardiology.

But in reading the report of the committee, I'm concerned that we preserve the nimbleness and responsiveness of a system of coverage decisions both to allow rapid adoption of technology and avoid placing already strapped hospitals in further financial jeopardy by forcing them to buy effective new technologies without offsetting reimbursement. And we'll talk about an example of that next.

So I want to make three basic points in this ten-minute slot. The first is that we really need a variety of evidentiary sources, randomized clinical trials being one of them, but also including registries, equivalence trials and OPCs to deal with different situations.

The second is to point out that the trials that are currently being done for FDA approval are large and very methodical and should be the first points considered as new technologies emerge from the FDA process and are
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considered for coverage. I'll talk a little bit about the fact that I do believe they're sufficiently generalizable to apply to the care of Medicare population by mainstream operators.

And third, that delayed HCFA coverage approval restricts application of new and better therapies and adds financial burdens to hospitals with an expense reimbursement gap as well as industry.

So I really want to cover that first point, the variety, the spectrum of evidentiary sources. At different points in the development of new technology, pilot registries may be valuable for proof of concept and device refinement, although not for the coverage

decisions you're talking about here, but broader registries that may contain thousands of patients may be adequate for approval of certain well-characterized devices.

Third, randomized equivalency trials are now being used by FDA to approve new generation stents that we'll talk about in a second and demonstrate noninferiority relative to other established therapies. The randomized superiority trials that the guidance document

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focuses on to establish superior outcomes or cost-effectiveness of high-volume, high-cost or high-risk procedures once they're mature versus the prior standard of care are not the only sort of valid evidence that needs to be considered in the coverage decision.

And finally, the importance of post FDA approval collection of population-based outcome data to document the use, patterns and risk-adjusted outcomes of competitive procedures for certain conditions in the real world should not be underestimated.

I just wanted to talk briefly about how this whole interventional cardiology got here, and it was through registries. The NHLBI PTCA Registry 1, in 1977 to 1981, lead to the adoption of this therapy, and the Registry 2, in 1985 and '86, documented the improvement in devices and technique. Katherine Detre from the University of Pittsburgh and I, with NHLBI funding, set up a third registry in 1989 that ended up enrolling some 4500 patients with seven new interventional devices and really still constitutes the largest series of patients with core angiographic laboratory evaluation of one-year follow-up for

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many of these devices.

That type of registry approach, however, was not sufficient to lead to the approval of stents. So in 1993 the first stent versus angioplasty randomized trials were performed within the NACI registry that use

single indications, a full randomized clinical trial machinery and lead to the approval of the J&J stent in a rigorous FDA process in 1994, making the United States the last of the industrialized countries to receive approval for this device. So it's a very slow process, randomized trials. Particularly as new technology becomes accepted, there's emerging reluctance to randomize stentable patients to conventional angioplasty, and that leads to a very prolonged approval for the second stent to try to go through this randomized comparison to angioplasty.

So how have the variety of stents that are now in interventional practice gotten through this FDA process? It's really been by a change in paradigm. And the change in paradigm that took place in 1996 was really to say we don't need to randomize stents versus angioplasty any

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longer, that documenting equivalency to approved stent designs would be also an acceptable approach. And the last half a dozen stents to be approved have been done in that format, usually a thousand patients randomized to a new versus an old stent. Recruitment is faster because everyone gets a stent, and it's a good solution to follow-on improvements and accepted technology. It has the rigor of an RCT, but without a placebo group. It can also monitor for improvements in stent designs, but it's a paradigm that's showing signs of age because showing equivalency to a first generation stent is probably not good enough, and it wastes the money of reconfirming the performance of the first generation stent in each successive trial.

So where we're headed in this new device era in 2000 and beyond is to develop OPCs, objective performance criteria, that will collect registry data and document performance consistent with the OPCs for stent performance. The reason I go through this series of evaluation paradigms is really we're right back now with registries,

and each of these different formats for evidence collection has been appropriate for a different
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point in the development of the technology. We can't just fixate on randomized clinical trials.

I just wanted to show you what this new device era has meant in our own practice, and this one shows in stacked bars the different therapies used in our program over the five years from 1994, when the J&J stent was approved, through 1998. Angioplasty is the bottom bar shown in red, conventional balloon angioplasty, which has now fallen to 21 percent in interventions. Stenting over that period has risen, the yellow bar, from 29 to 68 and now 79 percent last year in 1999 with two atherectomy technologies accounting for the final quarter.

So this adoption of technologies has really revolutionized our field. The J&J stent, as we said, was approved in 1994. And Medicare decision about coverage and assignment to DRG 116, however, did not take place until 1997. And in those three years between FDA approval and Medicare reimbursement coverage, the hospitals were having to buy this effective technology from manufacturers without any incremental reimbursement, and it contributed in no small way to the financial deneument of many of the leading
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institutions.

Now, one could say this rapid adoption of technology is just to appease technology-crazed operators, but this shows the corresponding incidence of major complications over that same time period. And the adoption of these technologies has in fact cut major complications in half, so we need to keep facilitating this rapid adoption process.

I just want to close by taking you through one of the trials, a Boat trial and atherectomy trial, to give you a flavor for the generalizability of the Medicare population. This trial enrolled a thousand patients over a

one-year time frame, actually 16 months, to angioplasty versus atherectomy. This was done at 36 centers, and this shows that they are geographically distributed, and they're both active practice centers.

One concern is the age of patients, and what I've shown on this is the cumulative distribution in yellow of our own interventional patients whose median age is 64 compared to the age in pink, I guess, of 12 trials with 8,000 patients that have been run by our daily

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coordinating center showing the median age of 63. So the age distribution in the interventional trials is representative of about half the Medicare population of routine practice.

The issue about few golden operators driving the results of these trials, I think, is addressed here showing the center-by-center performance in this trial. There's a wide variety of operators and operator experience, and as you can see in the DCA results shown in the yellow bars, in terms of residual stenosis there's a wide variety of practice patterns. Thank you.

DR. SOX: Thank you very much. Our next speaker is Wayne Roe, who is Chairman of Covance Health Economics & Outcome Services in Washington, D.C., and he's speaking on behalf of the Health Industry Manufactures Association.

MR. ROE: Good morning. I'm glad to be here. I'm actually speaking on behalf of myself. I'm speaking at the behest of HIMA. I have lots of reasons to have conquest in this business, and I do a little bit of consulting in the coverage policy area, very little bit from the old days. I'm on the boards of six medical

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start-up copies in the California area, involved with three venture capital firms who fund life sciences companies, all of whom will have things that will come before HCFA someday, but maybe not for three or four years.

I think HIMA asked me to be here because I spent the last 15 years getting gray hair by coming to HCFA and working on coverage policies for probably over a hundred different devices, drugs, diagnostic tests and surgical procedures. I've learned a lot about the process, got a lot of headaches through the process, have a lot of respect for the people doing coverage, and I think this group has its work cut out for it. This is incredibly complicated stuff, as you hear today. It's not simple, it's not trivial, and it can be academic and inherently judgmental no matter what you do.

I'll start out with just a few comments. HIMA doesn't know what I'm going to say because I wrote this last night when I was helping my daughter do chemistry, having read your paper several times. I want to commend the MCAC. I think you've done some very thoughtful work. I think in 11 or 12 or 13 pages there's

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lots of good stuff in there. I'm not going to try to wordsmith it at all. I congratulate you on seven categories on the size of health effects. I think those are pretty novel, pretty creative. I think they really importantly reflect the fact that most new technologies in medicine, like it or not, are incremental. They have a whole wide range of possible effects, positive and negative.

Unfortunately, we believe there are too few breakthrough technologies. It seems to be the way things work. I wish we had more of them. I think we want to encourage people to have more of them. But I think having those categories three or four that clearly ought to lead to positive Medicare coverage decisions is kind of a good way to kind of simplify the world.

I spent the last ten years telling medical developers I think they should stop thinking about thinking about themselves -- and a lot of this comes out of reading the work of Dr.

Brook and Hal Sox and David Eddy and so forth -- stop thinking about themselves as making tools or making drugs, but think about themselves as

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changing outcomes or changing the practice of care. And if they don't do the right kind of research or science to demonstrate a change in how their product has an impact on how the patient does or at least how the patient is managed, then they shouldn't be bringing their technologies to HCFA or Blue Cross Association or anyone else.

I think by and large that kind of admonition, which lots of people have been saying is getting through in the overall level of science, in the life sciences world, is a hell of a lot better today than it was 10 or 12 years ago. There's no question about it. No one even thought about any kind of randomized study, even controlled study, 12, 14, 15 years ago when I entered the device industry and we had the old National Center for Healthcare and Technology, which said many of the same things we've said that you are trying to say to today.

And I encourage you to appreciate really that the document you're writing here is going to be a sentinel of technology gatekeeping. We don't like to think this sometimes, but the bottom line is it's going to

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get read by lots of people, the final document, and it's going to be used by lots of people to make decisions. It's a gatekeeping signpost. Obviously HCFA is a gatekeeper, but you all are the experts.

We have a luminary panel here, the best and brightest we have in terms of doing outcomes research, and I think it's appropriate and important for you to encourage better science, to challenge the innovators to do better scientific work. And I think the tone of this should be to do that. On the other hand, I think it would be very bad to discourage them, to tell them well,

we want everybody to high jump eight feet, and less than eight feet was never going to be adequate, but you know, we really know behind the scenes six, five or six, six is going to be okay. I think that's a discouraging kind of tone, and I encourage you to take a look at the tone again.

HCFA staff and the care and medical directors, as we're here today, to private managed care medical directors, will read what you say, and they'll use it. You don't want to give them the excuse to hide behind it, to not

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make decisions, to put everything on randomized controlled trials, because the bottom line is we're not going to have them all. We're never going to have them all. And it would be kind of an academic pipe dream to expect we're going to have it. I don't think you should set the bar so high for people to use that as an excuse not to make tough decisions, not to allow progress in medicine. So please be realistic. You can't be academic in this exercise even though you want to be.

I guarantee you I've been through this. Somewhere in Menlo Park, California there is someone sitting down making a decision to fund $20 million for an Internet taco business versus some promising technology that will gather up plaque during cardiac endarterectomies that might save one of our lives someday. You don't want to discourage those people who might get the money to do the atherectomy device or filtration technology with the idea that you have to have two huge randomized controlled trials in order to get coverage. That is just a bad thing to send. But those decisions happen all the time with increasing frequency. You've got your capital

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world and the pharmaceutical firms and so forth who are going to read this document and look at it, and they're going to look to you for some guidance. Give them hope, give them a challenge,

but don't let them feel like it's hopeless because they'll go and fund those Internet taco businesses, and I don't think we need that as much as we need things to deal with endarterectomy.

Specific suggestions. First, I find it quite amazing -- a little hyperbole in all of this, of course -- that there's no mention whatsoever -- maybe one mention -- of the FDA standard of evidence or labeling in this document. Everything goes through the FDA to start. I know we all in the coverage policy arena realize maybe it's not enough sometimes, but every new technology is studied with the FDA in mind. And the FDA has very good outcomes researchers there, and they require sometimes randomized trials, sometimes not randomized trials, sometimes controlled trials, sometimes not, depending upon the product. It seems to me there ought to be some recognition that the FDA is enough for certain things, particularly

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pharmaceuticals.

The concept that people do well-controlled randomized trials, two of them in pharmaceuticals, for the purposes of demonstrating safety and efficacy and they're labeled to do and not to say hey, those things we're not going to take a look at and do a report on just seems to me to make your job more difficult and question what we have the FDA for. So I'd take a hard look what the FDA says.

I had these discussions years ago with the Food and Drug Administration. For whoever you talk to, the people I've talked to up there say when we approve something, be it a device, drug, diagnostic test, we're not approving it for Stanford, Hopkins or Cleveland Clinic. We believe that if we let it in the marketplace, it's going to work when lots of people use it, everybody uses it, the average physician who is licensed and capable of using it. You may question that, but the FDA doesn't say that. If

we think that only certain experts can use it, it's going to be effective there, then we're going to put that in the labeling and restrictive. So take a look at that question.

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You heard this before. The document in places, I think it needs more tone editing. Far too much weight on randomized controlled trials as the desired level of evidence. We're going to have them, we're going to have more of them, but they're going to be rare. And we can't afford them all. And we all know there are lots and lots and lots of reasons why we can't do them. And the FDA doesn't require them every time even for drugs. So I think you have to recognize that. There's lots of good science being done far better than before. Overemphasis on randomized controlled trials is going to make other research seem inadequate, and I think it will lead to some research not being done, some good research not being done, and things not being developed.

I think in the probably hundred things I've taken to HCFA over the last 15 years for national coverage evaluations or at least a peek at the national level without decisions being made to float down to the care level, maybe five technologies had very good powerful two or three randomized controlled clinical trials, but I never brought anything up here that wasn't pretty

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good scientific evidence that would lead someone to believe this is something that should have a good shot at being covered, and I'd say two-thirds of the time they were. So I'd go back and recognize that there's a pragmatic end to this area, and if you put five or six clinical experts in a room before you to develop a technology, you can probably get to a scientific result that will make people feel that there's a benefit there.

I think there's a serious source of bias in this document. The bias is against new

innovations. Effectively what you're saying here is -- and Dr. Brook and others have published on this -- ten percent or less of all medicine that we have right now has any scientific controlled studies done on it. This effectively says we're grandfathering all the old stuff. We're not going to take a look at what we're comparing it to. We want you to compare it to the old stuff. What if the old stuff's never been studied? To me one of the biggest problems we have in technology evaluation of coverage policies is we can't get rid of the old stuff.

For example, if the HMOs feel that ABMT

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for breast cancer is not any good, are they still covering it today? We need to take a look at this. We've got to get rid of the old stuff and question that before we just say the bar's higher now for everything new. The science behind everything new is definitely better.

Timing. I worry about how long this is going to take. Reports, consultants, et cetera, there's no way this is a six-month deal. It's hard to believe. There may not be enough top flight people with time who aren't publishing and doing research to be able to do this evaluation. I think MCAC should seriously take a look at talking with HCFA on provisional coverage. If the data isn't quite right, but we think it's promising, then let's think about a situation where we set out these are the outcomes we'd like to have you take a look at. We will cover for a fixed time period and stick to it, six months, a year. This technology and other things that are being done require you, the person who's getting the benefit of having the thing covered, to collect the information, come back to us a year later because the clock stops, the coverage stops here till you give it to us. I think you need

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some kind of innovative idea here which will allow research to be done.

So in short, be realistic in what you

ask for. Use the FDA. They've got to have a role here. Don't ask for what you can't have. It's very discouraging. Question the old stuff. Don't be advised against the new. And time is money and opportunity. I think you can incentivize better science with coverage, and we're not doing enough of it now, and I think that can be done even within the legal parameters. Thank you.

DR. SOX: Thank you very much. At this point we've earned ourselves a break of about 20 minutes. So be back at five minutes after 10:00 o'clock.

(Whereupon, recess taken -- 9:45 a.m.)

(Whereupon, after recess -- 10:05 a.m.)

DR. SOX: If I could call the meeting back to order, please. The first speaker is Vicki Gottlich, Center for Medicare Advocacy and Healthcare Rights Project.

MS. GOTTLICH: I'm Vicki Gottlich, an attorney with the Center for Medicare Advocacy and their Healthcare Rights Project in

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Washington, D.C. The center is about 15 years old. Our organization represents low income Medicare beneficiaries. We currently have about 60,000 open case files in which we're trying to get Medicare to pay for medically necessary services for our clients.

I appreciate the opportunity to speak here today, and I particularly appreciate the opportunity to be representing beneficiaries before this committee.

It is imperative for our clients that HCFA establish a mechanism for protecting the rights and interests of beneficiaries to receive medically necessary care and services authorized by their doctors. The current processes available to beneficiaries, the claims and appeals process and the national coverage determination process under discussion today do not protect beneficiary rights. Our clients and other beneficiaries have had limited success with

the NCD process often because that process has not been open to them. Few patients know they will need a procedure or technology when the process is underway, and even if they have timely knowledge, they generally do not have the

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resources to participate in the process.

Of utmost importance, the current process for evaluating new procedures and technologies and for reevaluating previous coverage determinations is too slow. Conditions deteriorate, and beneficiaries die, and I really want to emphasize that we have had clients die while waiting for HCFA to decide to cover services, technologies and devices covered by other insurers, including private industry, the Department of Veterans Affairs and state Medicaid agencies.

We applaud the subcommittee for their efforts to clarify the national coverage determination process. We are greatly concerned, however, that the process used by HCFA and under consideration today exceeds the agency's authority by depriving beneficiaries of services prescribed by their physicians for extended periods of time.

Let me explain. I really don't need to describe to this group what the Medicare statute says because you're all familiar with the Medicare statute. And the statute provides that services will be covered as long as they are

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medically necessary or Medicare will not pay for services that are not reasonable and necessary.

The key point to the exception that HCFA will not cover services is a determination by HCFA that a service is not reasonable or necessary. In other words, Congress placed the burden on the agency to overcome the presumption that the service is covered. Congress did not prohibit coverage of services prescribed by beneficiaries' doctors simply because enough or the right kinds of studies showing their positive

value have not yet been amassed. This interpretation is in keeping with the prohibition against controlling the practice of medicine or the manner in which medical services are provided.

But the proposals today follow HCFA's practice of placing the burden of proof on the proponent to show why a service or technology should be covered and to produce evidence of a certain type in standard that is not always available or even appropriate to the beneficiaries who actually need the service.

The proposals do nothing to assure that beneficiaries will receive quick access to the

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services their own physicians found reasonable and necessary.

For example, the suggestion that outside experts be used in certain situations to evaluate the evidence exasperates the delay problem. In addition to harming beneficiaries, such delays cause further disparities between Medicare and private insurance coverage and result in carriers having to deny Medicare coverage for services they cover in their own private insurance practice.

The proposals also fail to address adequately the needs of the over five million beneficiaries under age 65. Many members of this community are adversely affected by HCFA's failure to include new devices and technologies among Medicare's covered services. Delays in the processing for approving devices and technologies result in beneficiaries with disabilities losing their independence or their ability to function to their maximum capacity.

Beneficiaries with disabilities are also adversely affected by national coverage determinations that are based on evidence applicable only to the population over age 65.

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For example, the Office of Civil Rights of the Department of Health and Human Services

last year worked on and assisted a Medicare beneficiary in her mid 40s who was denied coverage of a potentially life-saving cancer treatment because of a national coverage determination. The national coverage determination was based on evidence that the treatment was not efficacious for women over age 65. Ample evidence existed, however, that the procedure was effective for younger women, and the Medicare HMO in which the woman was enrolled covered the procedure for its non-Medicare population.

While the appeals process is not a concern of this group, it is really an important element for our clients because the appeals process provides no recourse for beneficiaries who seek to challenge the national coverage determination or to get Medicare coverage of a technology or device not yet approved by Medicare. The Medicare statute makes it nearly impossible to challenge a national coverage determination rule upon which services were denied by preventing consideration of the issue

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at the administrative level. If the claim reaches federal court, a federal judge who determines that the record is incomplete or insufficient to support the validity of the national coverage determination must remand the case for supplementation of the record. The court may only determine that an item or service is covered after review of the supplemented record.

So the individual who was adversely affected by the obesity ruling that was discussed earlier today would have to go through the whole national coverage determination process and couldn't go through an appeals process in order to change the ability to get coverage for treatment for obesity. If the national coverage determination process is as lengthy as the appeals process, it is going to be years, and that's why we are very concerned about the

delays.

In sum, we are not advocating that Medicare pay for quack services, which have been shown to lack medical value. We are advocating for an efficient coverage determination process that allows Medicare beneficiaries to receive

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Medicare payment for services and procedures, devices and technologies that have been approved by the FDA where appropriately are being covered by private insurers, the VA and Medicaid, and are found by the beneficiary's own physician to be reasonable and necessary for treatment of that beneficiary's illness or condition.

We also seek an effective and expeditious appeals process that will allow beneficiaries to challenge a denial of coverage based on an NCD that is no longer supported by medical evidence and practice. And while that's not within your jurisdiction, we do ask that you consider an expedited process to consider NCDs that don't have any support for them. And there are a lot, as I'm sure that you are aware. Thank you very much.

MS. LAPPALAINEN: Vicki, would you state for the record whether you have any financial interest in the --

MS. GOTTLICH: I'm sorry. Our organization has no financial interest in any medical devices, and neither do I. Thank you.

DR. SOX: Our next speaker is Larry Weisenthal from the Weisenthal Cancer Group.

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DR. WEISENTHAL: My name is Larry Weisenthal. I'm a medical oncologist in private practice, and I provide the service that I'll be describing. I'm a medical oncologist from Huntington Beach, California. I participated in the Medicare Coverage Advisory Committee meeting last November 15th and 16th. My experience related to this meeting is what now compells me to offer comments concerning the structure and procedures for future MCAC reviews.

My specific concerns involve, one, serious defects in the advanced draft outline of the proposed review process, and two, a lack of appreciation for special considerations related to laboratory testing in a draft proposal which seems exclusively directed toward the review of direct therapeutic interventions.

Rather than speaking in a theoretical sense, I would like to use my own experience with the November MCAC meeting to convey my concerns. The draft proposal places heavy emphasis on a series of independent reviews by so-called experts in the field. Essentially the process would be centered around a collection of up to six independent written reviews by these

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experts. There would appear to be a relatively small role for the proponents of the technology under consideration as they would have no opportunity to rebut these reviews in advance of the meeting. One can easily project proponents having to use their entire 15 or 20 minutes or less of allocated time at the meeting just to hurry through complicated rebuttals of complex and misconstrued data.

The November MCAC meeting considered the issue of human tumor assays, which involved short-term cultures of fresh biopsies of human tumors in the presence and the absence of anticancer drugs. Following cell culture, drug effects are assessed by one of two end points, either cell proliferation or cell death.

Historically all work in this area was effectively abandoned in American universities in the mid-1980s. The only major academic group continuing work in this area was the lung cancer group at the National Cancer Institute. However, the NCI investigators had a primary focus on creating cell lines through passaging and subculturing. I anticipated a major emphasis on three public studies arising from this work, and

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I quoted several pages of my proposal, submitted

two and one-half months in advance of the November meeting, to a detailed rebuttal of this work.

Fearful that this rebuttal would be overlooked, I was also forced to devote precious minutes of my oral presentation to this issue, which gave me no time to take the committee through the many important positive studies and prestigious peer-reviewed journals, which were included in my written proposal, but which were ignored by all the reviewers chosen by HCFA.

The major reviewer of the cell death technologies proposed for coverage by me was Dr. Edward Sauceville, associate director of a developmental therapeutics program at the National Cancer Institute. Dr. Sauceville did not attend the morning presentations by the proponents and their supporters. This led to the following embarrassing statement, quote, you can tell a patient who has the unfortunate diagnosis of pancreatic cancer that they're likely not going to respond to a medicine chosen after having gone through an additional test to obtain tissue and then test it for assay resistance.

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This statement was embarrassing because one of the earlier speakers had been a pancreatic cancer patient who has been in complete remission for more than three years after presenting with liver and kidney metastases and then being treated with an assay-selective drug regimen, which everyone agrees would never have been chosen absent performing the test.

Dr. Sauceville was also either not shown or did not bother to read my written proposal submitted two and one half months in advance of the meeting. He showed his complete ignorance of the field by failing to even mention, much less consider, 80 percent of the studies, totalling more than 1500 patients, confining his review almost exclusively to studies published before 1987 and to the irrelevant studies that the NCI lung cancer group

alluded to previously. Neither did he nor any of the other HCFA reviewers review and describe most of the many studies correlating assay results with patient survival.

Again, all these data references were provided to HCFA two and a half months in advance of the meeting. Nonconsideration of these

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studies led to the following remark at the December Executive Committee meeting by one of your members, Dr. Ferguson, who related, quote, we had very little survival information. There were some unsettled elements. I don't remember that there were other ones.

This remark forced me to make the following frustrated comment at the December Executive Committee meeting, quote, there were many misrepresentations made, such as the lack of survival data. I showed a slide at the meeting. There are 15 studies showing strong correlations with survival. This is not just based on response.

That the above assessment of the inadequacy of the outside review process is not just a figment of my imagination was shown by the comments of the committee chairman Dr. John Ferguson again at the prior meeting of this Executive Committee in December. Quote, another was that the NCI representative presented a paper which in my view I was a bit disappointed in coming from my former institution that it did not seem to me to be up to date and lacked in that aspect. Dr. Ferguson went on to say so I am not

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certain that the protagonists were given all the critiquing information. We didn't have it. We tried to give the protagonists time to respond. I think that that could have been done a little bit better in the sense that if all the critiques of presented papers could have been given to the presenters in advance, they might have had time to prepare some rebuttal in response to the critiques.

Even more egregiously misleading than Dr. Sauceville's inadequate review was the horribly misleading review of HCFA's Dr. Burken, which by objective evidence demonstrably and unfairly damaged the case put forward by the proponents. By way of background, one of the technologies proposed for consideration of coverage was the cell proliferation assay based on measuring tritiated radionuclide incorporation as an assay end point.

Data was presented to document the high specificity of this assay in identifying drug resistance. In his review of the literature, Dr. Burken devoted considerable time to technologies which had been abandoned 10 to 15 years previously and which were not proposed for

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Medicare coverage by anyone in the November review. One of these abandoned technologies was a radionuclide precursor incorporation assay measuring the incorporation of tritiated thymidine or uridine only three hours after the addition of anticancer drugs to freshly disassociate the tumor cells.

This contrasts with the technology under MCAC consideration which measured thymidine incorporation five days -- not three hours -- after drug administration. Whereas the five-day assay predicted for drug resistance with very high specificity, the three-hour assay gave very poor results and was abandoned by its own proponents in the 1980s. Yet Dr. Burken showed four different slides detailing the poor results with this assay. This demonstrably confused and mislead the panel, as conveyed by the panel's industry representative, who showed us a table constructed and to specify the MCAC panel depicting the negative predictive accuracy reported in the various studies and prominently including the four studies with the long abandoned three-hour assay which showed such poor correlations.

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The verbatim transcripts of the MCAC panel's deliberations revealed the damaging effect which the inclusion of these irrelevant studies had on the MCAC enthusiasm for coverage. Although clear from the transcript that there was overwhelming support for HCFA developing a policy to include coverage of these assays in at least some clinical situations, this support would have clearly been less reserved in the absence of the misleading presentations by the reviewers chosen by HCFA. This is crystal clear in the transcripts of the meeting.

But the purpose of my comments here is not so much to complain about the past as to help the Executive Committee develop a better process for future reviews. To this end we must begin to appreciate that we are working in a time when an increasing number of important advances in medicine are occurring outside the traditional NIH and university research system.

In the case of human tumor assays, there are no experts at all in either American universities or at the NIH. No investigator at these institutions has contributed in any way to the literature in the field I represent of cell

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culture drug-resistance assays with cell death end points. In my 20 years of full-time work in this field, I've talked with hundreds of university and NIH-based investigators with an opinion about this field. It's been more than ten years since I last had a discussion with a non-European and non-Japanese university-based investigator to be able to discuss the subject based on an intelligent understanding of concepts and literature.

So HCFA must be very careful to ensure a central role of the proponents of the new technology in presenting and explaining data to the MCAC panels.

Cutting to the chase, we propose the following modification in the overall outline of the proposed system. First, the process begins

with a formal request to HCFA for coverage consideration. Once informed that HCFA agrees to consider the issue, the proponents are responsible for presenting a formal defense of their proposal centered around a description of technology and complete review of all relevant data and literature. This proposal is then sent to each of the outside reviewers. The outside

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reviewers then prepare their own independent reviews, which are then given back to the proponents for rebuttal. The rebuttals go back to the reviewers who are allowed to have the final word in the pre-meeting written presentations and reviews provided to the MCAC panel. The proponents should also certainly receive a copy of this final review while in advance of the meeting.

The meeting itself could then take place with all the complicated and contentious issues having already been pre-argued. The meeting itself would begin with relatively brief summations by both proponents and reviewers, followed by a devotion of most of the time to open discussion by the committee with committee-directed questions to both proponents and reviewers. However, prior to final deliberations and votings, both proponents and reviewers should have the opportunity to make brief final remarks.

I've got one page here which I won't go over the time, but could this be put into the record?

DR. SOX: Sure. If you want to submit something in writing.

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DR. WEISENTHAL: Thank you.

DR. SOX: Our next speaker is Sandy Sherman, Assistant Director of Division of Federal Affairs & Outreach of the American Medical Association.

MS. SHERMAN: Good morning. I just have a brief statement from Dr. E. Radcliffe Anderson, who's the Executive Vice President and

CEO of the AMA, regarding your discussion paper.

After the first MCAC Executive Committee meeting in December, I wrote to Nancy-Ann DeParle to say that the AMA was impressed and gratified by the commitment of the advisors and HCFA to ensure that MCAC recommendations would be grounded in scientific evidence of clinical effectiveness. I also said that the meeting made it clear that she had fulfilled her promise to create an open, timely and accountable process for making national coverage decisions.

The discussion paper that the committee members prepared for today's meeting underscores the observations we made in December. The recommendations for evaluating evidence clearly state the key issues to consider in assessing the

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state of the knowledge regarding medical interventions proposed for Medicare coverage. We are pleased that in addition to recommending a critical review of evidence from clinical trials, the Executive Committee or the members who prepared this proposal recommend that the standard of excellence for the evidence report include work developed by the national medical specialty societies. We also commend the advisors for recommending that panel members take an active role in framing the questions to be addressed by the evidence report, participate in the report's preparation and seek external review of the evidence reports.

Prior to the MCAC's formation, the AMA had expressed concern that Medicare coverage decisions might be driven to a large degree by information presented by those with a vested interest in coverage instead of by the available scientific and clinical evidence. The discussion paper developed by the advisors has allayed our concerns in this regard, and we encourage adoption of its recommendations.

DR. SOX: Thank you very much.

Our last speaker is Thomas Meskan,

president of Medical Alley.

MR. MESKAN: Good morning. My name is Tom Meskan, president of Medical Alley. In terms of your financial statement, obviously we have members who pay dues to our association, and I presume that a number of them have issues pending before the agency.

For those of you who aren't familiar with Medical Alley, we're a 15-year-old not-for-profit trade association based in Minnesota who has members from all aspects of healthcare. Our members include health plans, medical device manufacturers, hospitals, clinics, long-term care organizations and academic health centers. Our mission is to serve as a collaborative form which promotes an environment to enhance innovation in healthcare.

I appreciate the opportunity to share our perspective and thoughts as they relate to the discussion paper. We think that the MCAC process is an important aspect of Medicare's decision making and want to acknowledge and express our thanks for the time and effort all of the people, both you as panel members and agency staff, are spending to try and make the MCAC a valued component of Medicare decision making.

To help you get a sense of the orientation of our organization, I will point out that we believe that Medicare should be a prudent purchaser of services, and we think that it is important that the agency has appropriate levels of resources to do its job. At the same time we believe that the environment surrounding Medicare, and for that matter, all of healthcare, should be dynamic so that patient care improves in a timely and continuous manner.

With regard to our principles on generating evidence, they are that HCFA preferences for how evidence is presented should be transparent. Any approach to decisions about coverage criteria should be administratively

feasible for both the agency and the stakeholder. It is desirable that stakeholders achieve the level of valid scientific evidence necessary to demonstrate that a service should be covered, and there should be a minimization of potential for bias into conduct, reporting and analysis of studies.

Our comments today fall into two categories. First, we want to offer some

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observations about the role of perceptions in the success of your efforts. Second, we will offer some specific reactions to some of the text in the discussion document.

It is clear by looking at the names which make up this committee and the impressive roster of individuals that make up the MCAC panels that there is a wealth of expertise available to the agency. I had the opportunity to introduce myself to Dr. Sox during the break, and he, if I can paraphrase him, said what he liked about his involvement in this committee is its potential effect to a large number of human beings and their health condition. And I think that that's a very accurate statement. And the most important point is we must make sure that you guys do everything you can to maximize your potential.

Obviously each of you are approaching your MCAC responsibilities in good faith and with a desire to achieve the goals of consistency and accountability. Further, you have laid out the recommendations in a manner which strongly signals your interest in promoting the greatest possible degree of rigor in the methods used to

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generate evidence.

We too want to encourage the development of a decision-making process that will be informed, and we also support the continued improvement in the way the supporting data is collected and utilized. Nonetheless, this committee, the agency and external

stakeholders must acknowledge the history of coverage policy development so that whatever process this committee decides upon enjoys support of the largest possible percentage of affected stakeholders. In this manner you can ensure that your time and efforts are valuable.

In brief, that history suggests that whatever approach is taken by the agency and those who advise it to create greater detail on the concept of reasonable and necessary will be subject to extremely close scrutiny.

We know the examples, a coverage regulation that has been kicked around since 1987, the fact that this committee is just starting to get off the ground two years after the GAO found the act to be in violation of FACA. We also know that frequently in coverage decision making it becomes subject to second-guessing by

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Congress.

We raise this because we want to encourage you to get this process off on the right foot. We want the MCAC process to succeed and be used. And while I heard Dr. Bergthold's comments about the effort that you went towards submitting this, it serves no one's interest if your approach is perceived incorrectly or not as so academically grounded that MCAC becomes nothing more than another health policy center which provides insights that have little life beyond those who formulate and to make them internally.

We believe it is fair to say that outcomes research and technology assessment are evolving disciplines. Further, while the document does not say so, it is extremely rare that data is ever perfect. Similarly, a number of decisions faced by panels are likely to inquire around one of the truisms that surround healthcare. That is part art and part science.

Therefore, we encourage you to modify your discussion document to acknowledge these factors and create the opportunity for our

acceptance of your approach. Similarly, it will
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enhance your opportunity to improve the effectiveness of the panels.

We offer you the following language as an example of a kind of statement that you might make. Evidence presented to support a coverage decision should be deemed acceptable if it is ethically appropriate, administratively feasible and if it meets the current generally accepted used requirements for evaluation of a health service typically found within a technology assessment literature that were in place at the time the study was undertaken. This is not to say that the evidence is then accepted as meeting a case for coverage, but rather reflects a common sense approach to considering the practical implementation issues which surround the methodology options for generating data.

It is simply the case that a majority of the people who are involved in generating evidence for decision making are well-meaning people who want to do the best job they can. This does not mean that they are at all as schooled and knowledgeable as you on the nuances of evidence generation. Your document needs to implicitly acknowledge these individuals and to
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speak to them in a manner which allows them to see clear, feasible pathways to being constructive contributors to Medicare coverage decision making.

We suggest that with that opportunity comes an obligation. We would suggest that the document be modified to express the interest of panels in receiving from stakeholders the rationale which drove such things as the study design, data sources utilized, the rationale for what the service is being compared to, the time horizon that's chosen and the statistical analysis methods used to address random events. In addition, we think it's appropriate for stakeholders to describe this data from

unpublished sources. This will provide useful information to the panels as they seek to weigh the value of the evidence presented.

Let me now move to our observations about the specific aspects of the document. First of all, we would note that the paper fails to acknowledge those stakeholders who have already completed or are currently in the process of carrying out efforts to generate data for a national coverage decision. The paper needs to

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provide some guidance so that these stakeholders and/or the panels do not feel that an organization must necessarily go back to square one in generating evidence because of this document.

Moving to another area, while we recognize the panel's purpose is to focus on issues of science and evidence, it's somewhat ironic that the words or concept of a patient do not appear until page 6. While the document's failure in this regard could be seen as semantic window dressing, we believe it's important that we all keep front and center in the end. This is what we're all about.

That said, the committee has indicated its interest in the panel's making conclusions about health outcomes. We would ask that the committee modify the text on page 7 or at least my Internet version on page 7, item 3. This text addresses the need for the panel to explain its conclusions. We suggest that the committee ask the panels to describe as specifically as possible how each of the various health outcomes, including, but not limited to, mortality, morbidity, functional status, quality of life and

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patient experience were factored into its decision making. By making the reporting requirements more detailed, the goals articulated in this item will be better achieved.

We also believe that significant thought should be put into the item on page 7

about the evidence reports provided to the panels. Although the ability of this proposal to operate in a timely manner is suspect, we are also very concerned that the document does not in any way provide affirmative action between the stakeholder and MCAC on what materials will be contained in the evidence report. We think the document should provide a mechanism for dialogue between stakeholders and the appropriate panel representatives before submitting the report.

Another area of concern is found on page 5, the last sentence dealing with bias. The text can be read to require that the panels describe why bias does not account for the results. Conversely, the subjectivity, if you will, in judgment calls which are involved with these issues, we believe that the panel should be empowered to describe why it's comfortable with its conclusions.

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Finally, on page 6, the last two sentences on external validity, the terms typical practice setting and general practice setting appear to be used interchangeably. Because of the importance that the agency puts on appropriateness of making decisions, we believe it would be valuable to clarify what the terms typical and general mean.

In sum, we believe that all Medicare stakeholders are benefited by the recognition that improving the Medicare coverage decision-making process is a long road. We believe the MCAC process is an important resource for the agency and for external stakeholders, but at these early stages of this effort care must be taken to create conditions for success. We know that the talent, insight and good efforts exist on this committee to achieve these conditions. We stand ready to assist you in every way we can and thank you for your attention and consideration of our views.

DR. SOX: Thank you very much. Before we go on to the HCFA presentation, Sharon's going

to read a letter that we just received today from the ACP-ASIM on the same day that AMA commented
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on our document.

MS. LAPPALAINEN: The letter is addressed Dear Ms. Lappalainen, the American College of Physicians-American Society of Internal Medicine (ACP-ASIM), representing over 115,000 physicians who specialize in internal medicine and medical students, wishes to offer its comments and concerns on the draft report of the subcommittee of the Medicare Coverage Advisory Committee's Executive Committee entitled, Recommendations for Evaluating Effectiveness. ACP-ASIM is generally supportive of these recommendations, but feels it critical that the MCAC strike a healthy balance between assuring a coverage review process which is credible and defendable from a scientific viewpoint, yet not so mired in technical detail that final coverage decisions are unreasonably delayed.

ACP-ASIM is very supportive of the draft report's objectives; that important clinical coverage decisions be reviewed on the basis of sound and objective clinical evidence by the MCAC's six medical specialty panels, and that there be a standardized methodology and format
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for panels to present their recommendations to the MCAC Executive Committee, thereby allowing the Executive Committee to make uniform, high-quality and scientifically defendable coverage recommendations to HCFA. We also support the draft report's recommendation that the MCAC only focus on the clinical and scientific questions around the medical effectiveness of new items and services and the comparative effectiveness of new items and services relative to existing alternatives, and that the MCAC not address questions about dollar costs of new items or services.

We are impressed with the amount of

scientific rigor the draft report proposes for assessing the adequacy of clinical evidence related to a new item or service and calculating the magnitude of the health benefit such coverage would have on the Medicare population. We do wish to raise some technical concerns under the draft report's section on Evaluation of Evidence.

On page 3 the discussion of potential sources of bias has some noteworthy ommissions, including double-binding, perfect compliance,

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adequate length of follow-up, distinct treatment separation and inappropriate statistical analysis. Imperfections in any of these would permit bias to enter into a randomized controlled clinical trial and thus make the results less valid for the population under study and thus difficult from which to generalize.

We also feel the draft report's recommendation on page 4, that MCAC panels be required to describe possible sources of bias and explain why a panel decided that bias does not account for the results, should be applied in all coverage decisions, not just the limited circumstance of uncontrolled studies described on page 4.

Also, on page 5 where seven categories of size of health effect are presented, there appears to be one category omitted, which we would recommend the addition of, more effective, but with disadvantages.

In summary, ACP-ASIM believes it is vital that coverage decisions remain in the hands of the medical experts comprising the panels of the MCAC and that the credibility of this body will depend on striking a balance between

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scientific rigor and decision making which is not bogged down in process. Decisions reached by the MCAC must be based on the best mix of objective data and professional judgment possible and lead to coverage recommendations that have a

compelling weight of evidence, yet are rendered in reasonable time frames to avoid work backlogs which might undermine MCAC effectiveness and credibility.

ACP-ASIM supports the MCAC coverage decision process and welcomes the opportunity to contribute to its evolution. We believe the time spent now will pay great dividends in the future and that the MCAC's evidence-based decision-making model will soon become one of which we can all be proud. Sincerely, it is signed by Whitney W. Addington, M.D., F.A.C.P, president. Thank you.

DR. SOX: We'll now move on to the HCFA presentation by Dr. Kang and Dr. Hill. Jeff, go ahead. Well, Bob, you had something to say.

DR. BROOK: I don't quite understand the transition here, and I'd like some clarification on the process. Up to now we've had a description of the subcommittee report and

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then a public session with public comment. What is this part?

DR. KANG: This is actually the HCFA comment.

DR. BROOK: Is this the response to our subcommittee report?

DR. KANG: Yes.

DR. BROOK: I'm wondering whether the process we ought to -- I mean since we are an advisory committee to HCFA, do we want to have some discussion of the committee before we hear what HCFA thought of the report in relationship to the public report or is this a process that's prescribed by law or something that we can't do this? I'm just wondering which way we want to do this since we're advisory to HCFA anyway. Do you want us to put all this together when we try to deliberate or just look at the public response first?

DR. KANG: I'm actually okay either way, quite frankly, because there's many of the issues here which have been raised which I think

we can resolve through discussion. So if we want to kind of cut to the chase here, that's fine with me.

DR. HILL: In the sense that the subcommittee asked for a comment and a report to be given, when something's presented to the panel, we also would like to be able to comment about the subcommittee report at this point and hope that you would take that into consideration in your mix.

DR. SOX: Alan, do you have a suggestion?

DR. GARBER: Just speaking for myself, I would like to hear HCFA's comments before the committee deliberates so we can deal with all of the comments as a whole.

DR. KANG: I'm going to nix my presentation then. I actually had only one comment then. Dr. Hill has a bunch.

I wanted to note that when I was a real doctor -- I guess I'm no longer a real doctor -- it's been awhile since I've practiced -- practicing geriatrics, I had to make very difficult choices and/or recommendations for my patients almost every minute of the day which diagnostic test to order, should I recommend hospitalization or home care, what treatment options should I suggest et cetera. Usually this involved choices amongst well-understood, commonly utilized possibilities.

Sometimes, though, something new or something new to me was as an appropriate consideration. Usually in these situations I turned to the medical evidence and the literature to help me make a choice in this decision. I think I did that largely in part because I wanted to be sure before abandoning the old that using the new would be better. I think in many ways this is what we're wrestling with, and this is what national coverage decisions are about that we face frequently with new technology. What

does the evidence or science say about the new technology?

In practice, though, I must admit I also recall the patient's condition and the availability of alternatives had a lot to do with how I reviewed the evidence. If our patient was in serious trouble and there was a lack of any other beneficial alternatives, it actually made me more likely to offer the service even if the literature was suboptimal. I think this was especially true if the risk of the service or procedure was very small.

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So I just ask in your deliberations today that you discuss whether or not the patient's condition, the availability of other alternatives and the risks associated with the service should affect how we actually view the evidence.

That said, I applaud and thank you for your efforts to deal with this in a consistent manner for all panelists on how we read the evidence. I believe that actually you're off to a great start, and there's many things that can be resolved today.

DR. HILL: Thank you. I'll be as brief as I can. First of all, I want to say on behalf of our group within HCFA that the subcommittee report is both admired and appreciated by us. Nothing that I will say should be taken as a denigration or a disparagement of this important contribution to HCFA's efforts to improve our coverage decision-making process.

The report's recommendations for an optimal process, speaking from the position of the people who are going to have to carry this out, appear to be well-challenging. It may be that at least for some decisions, we will have to

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commit to all the steps you outlined, but that possibility causes us as well as others to have a care for the time required.

This is the most open and accountable

process for making national coverage decisions in the history of Medicare. When we designed and started this new way of doing business, including the MCAC, we knew that the period required to reach a decision would often include required minimum components and time periods because of the steps. For example, announcing the planning of MCAC panels' open public meeting means some time is needed. As we talk today about how to prepare for and get the best advice from MCAC panels, we're thinking again about the time required. But let me be plain. We were not then, and we are not now, hiding behind the process to delay coverage, to delay getting the latest evidence-proven treatments to Medicare beneficiaries, and we do not want anyone else to either.

Our intentions and success in meeting those intentions are and will continue to be clear. We announce matters under consideration for coverage decisions on the web with due

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dates. If we can't meet our self-imposed deadlines, we give our reasons, again posting them publicly. This process must not be driven back into a black box by criticism of that process, including criticism of timing.

Our goal is to reach well-reasoned, scientifically sound decisions as rapidly as can be consistent with that level of quality. We believe that this committee shares that goal with us, and we appreciate its comments on how to keep things moving.

Let me refer to a couple of specifics in the subcommittee report that may raise concerns for process duration. The suggestion that each panel explain its conclusions in writing should not in our view delay a decision until a second panel meeting months later is voting on that right. We should be able to address this commendable desire for accountability, as consistently expressed in this suggestion, without more time than is already

contemplated to write up and post the summary of that meeting. This is something we're already going through.

The suggestions regarding the structure

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of the evidence presented to the panel should not delay. We are committed to presenting high-quality and well-organized information as called for in the subcommittee report and doing so within the time frames previously contemplated. We will get help doing this in a timely way when necessary, and we are already doing this for the next planned panels.

I'm pleased to see Dr. Deborah Zarin from our well-respected sibling, the Agency for Health Research and Quality, with us today in the audience. Dr. Kang and I have met on multiple occasions with AHRQ's leadership, and we look forward to their involvement as an important resource for us in examining evidence and preparing for MCAC panels. We'll be talking about the subcommittee's time frames with them.

Finally, on the time frame issues I want to respond to the subcommittee's item number 6, expert review of evidence reports. At the present time we are not planning to do this in every case. Even if time were not an issue -- and it may not be if this added step can be accomplished within current expectations -- we still regard this as a quality control feature.

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If we're doing a good job with the presentations to the panels and the postings on the web, if the process seems to be working without this step, we do not presently intend to make additional external review part of the routine.

The other major concern we have heard about the subcommittee report -- you've heard it too -- is that it seems to set some impossibly high hurdle to bar every new technology without any regard for type. We don't read your statement that way, but this should not be a concern regardless because we continue to explain

that we are not abrogating our responsibilities. We understand that we have to make the coverage decisions. You advise us, and we decide in part basing our decision on your advice. So we want to know the basis of your advice, your recommendations, your thinking. We will want to know what's behind the MCAC panel's inclusion about evidence. We don't expect the panel to, nor can we allow the panel to, decide for us whether or not there's enough evidence to allow us to cover it.

For example, when the subcommittee report says uncontrolled studies are never

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applicable, I read, in the context of that section, that if a clinical experiment reported in medical literature carries the possibility of bias in selection of patients, we understand the difficulties of explaining away that bias without randomization or other forms of controls.

Dr. Sykes gave a good explanation of bias in his presentation to the subcommittee report. Does the risk of unaccounted for selection bias mean that we shouldn't give the experiments' results much weight in deciding whether or not to cover the tested treatment? Possibly. Does it mean we automatically refuse to cover? No.

As the subcommittee report suggests, observations alone may sometimes allow a panel to make conclusions about effectiveness. Such suboptimal evidence may allow us to conclude that Medicare should cover the service. Deadly diseases without alternatives come to my mind immediately as such a situation, also logical consistency with general medical science understanding. The proof required to allow applicability to the Medicare population might be less where the application makes sense than when

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it's counterintuitive or inconsistent, hard to explain in the context of the rest of the science.

I also see no credibility in the assertion that the committee is threatening to tell HCFA that one threshold fits all. No one should take seriously the suggestion that we might require unrealistic trials such as double-blind tests of surgically implantable devices as a dodge to avoid covering something. We said, and I say again, that the sector-specific guidance documents are purely of our quality-oriented coverage plan, and they are the next step after a coverage regulation proposal in the federal register. We have already demonstrated, in the coverage decisions made so far under our new process, that we are aware of and can properly include the flexibility necessary for the variety of situations we face.

But the questions you ask are at least potentially constant, and the important questions you've asked of this document can't be ignored. We still want to know whether studies that do not focus on patients over 65 produce results that can be applied to the Medicare population of that

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age group. It's possible that the answer can be no or even unsafe over 65, and we might consider still covering, but only for our disabled and ESRD beneficiaries who are within the age range where medical benefit is shown by the evidence.

So to the subcommittee we say thank you for this important contribution. Thank you for these questions. To industry and those who want to cover our product or service, we say let's look together at these questions. We understand, and you know we understand, that these questions do not control HCFA's coverage decision making, but they will help inform and improve the quality of those decisions. And to our beneficiaries and the public generally we say we will be faithful stewards of your health and the health of the future beneficiaries. We will ask these questions. We will continue the work begun two years ago, always listening to the medical community, providers, consumers and manufacturers

and promoters, the work of improving Medicare's national coverage decision process. Let's keep going together.

DR. SOX: Thank you. We now go into an open committee deliberation, and what I'd like to

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suggest is that we start our deliberations and perhaps spend as much of the next hour as it takes to ask follow-up questions of people who made presentations to us, both from the public as well as HCFA, and then, again depending on how much time it takes us, either proceed on to starting a round table discussion of this document and what we need to do to come to a vote to recommend to HCFA.

So with that brief introduction, I'd like to focus for now on trying to ask questions of the various presenters and so forth. Bob?

DR. BROOK: Panel, can I raise a process issue of what we're trying to accomplish today? Let me tell you what I've heard. I didn't hear anyone except maybe HCFA have a -- I'll retract that. I didn't hear anybody sort of say the document is out of bounds. It should be burnt and thrown away. I've heard a lot of wordsmithing in some places, a lot of questions about tone and other questions, but no wholesale disregard for it.

The question I'm asking is should we consider on this committee a bifurcated process? We need something to help the next set of panels

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get started with. We could say that we've gotten there with this document as getting started, and we could ask the people that presented as well as other people to take the document we have and actually instead of doing what we did here, require them to do what we did ourselves, which is to white out, edit, alter whatever they would like in that document and provide a justification and a reason for what they're trying to accomplish by doing that and then take this so that we would actually have a written record that

basically would allow us to look at this paragraph by paragraph, sentence by sentence on the belief that both the people at HCFA and the people of the subcommittee and people of the committee will disappear sooner than we can probably imagine given our mortality.

And I wonder whether that kind of a process would be one that we would then have a written record of what people really would do to this document if they were all part of the subcommittee. And then the subcommittee would then take those, produce a written record of how we responded to that and in a document that then we would do and produce as a second version and

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continue to involve this process over time as we get experience with it.

So the thought here is go with what we've got now as advice to the committees to do the next round of the panels, get written input, continue to revise, continue to deal with this kind of a document and make it an evolutionary document with a history behind it so that we can continue the process forward.

And as we get feedback, both from how it worked in the panels, and what the public believes about this feedback, we could then continue to modify this document and do it as sort of that kind of an approach as opposed to us trying to ask questions, get off-the-cuff responses, some of them well thought out, but not sort of at the level of how would you change this sentence? When you mean tone, okay, what do you really want done here? So getting commitment in writing to what people really want done.

I'm wondering whether that would be a process that would get us further along.

DR. SOX: Let's discuss that. It's a reasonable proposal. Let's have some serious discussion.

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MS. LAPPALAINEN: Right. We have the document available for projection, and we are

prepared to have someone make edits now. For the entire afternoon we have set aside a large amount of time today for the committee to make those kinds of suggestions to the document. Because the subcommittee met in essence in private, the deliberation and the review of the document needs to be in public today in order to satisfy the Federal Advisory Committee Act. And this is why we have called the meeting today so that the entire Executive Committee could deliberate and review in open public format this document.

DR. SOX: Okay. Well, Bob, in essence, I think, has said that we need to get rolling with the process, that the document that we've generated so far doesn't have any deadly flaws in it, but at the same time we've had some very useful comments and perspectives that might strengthen the document if they were incorporated into it.

And perhaps we could simply have a two-part process, which we would decide whether or not to use the document as it is now to help the panels in their deliberations that are on the

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schedule right now and meanwhile give the public an opportunity for input into the document and reframe it as seems appropriate, then come back at our next meeting to present what we've come up with for further discussion and options.

DR. BROOK: That's not what I said. It's close, Hal.

DR. SOX: Thank you.

DR. BROOK: I think that we could have open deliberation today at the level of a committee about do we think this is good enough to overcome some of the major problems with the running of the next set of panels? And we ought to confine our discussion to that for us at this moment. But at the same process, I've heard that there are people that really want significant written changes in this document that we all may think there's no problem with, and it would improve the document.

And if we had a process of saying -- and I don't know the timing of this here, but you have six weeks to take this document and to write down, not just the edits, but just the reason you want it changed, the justification, what you're trying to accomplish, and then have the

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subcommittee look at that and then try to incorporate as much as this into a revised document and bring it back to the Executive Committee so that we get closer to what people really want and go through the step before we meet again as an Executive Committee of actually looking seriously at those changes and incorporating them, then we would have a written reason, a written justification, and then we could respond as a committee and say yes, we agree with, no, we don't, for these reasons. And this would be a different kind of a process.

DR. SOX: So we have comments. I was looking this way. So Alan, why don't you take the first one.

DR. GARBER: I'll be very brief. I just wanted to remind everyone -- and correct me if my memory is incorrect -- that at our last Executive Committee meeting we said that the subcommittee would produce a document that's really intended to be interim to provide guidance to the panels until HCFA issues its regulations. So one thing to keep in mind, none of us, I think, have the intention of producing something that's going to be permanent. If this does

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happen to coincide perfectly with the rules that HCFA eventually develops, that would be great. I don't think we have the expectation that that will necessarily happen.

So this is indeed an interim document, and I don't think the idea is to make this so pristine and perfect that it never needs to be changed because we are almost bound to change this in the course of the next year, year and a half, however long it takes.

The second point is that I think we said at the previous meeting that we hoped that we would more or less wrap this up at this meeting, and I think it's premature to talk about longer term changes until we've heard from the members of the Executive Committee, who did not yet have an opportunity to comment on the document, to get some sense of whether this is very close to the right ballpark and just needs some technical revisions that can be handled today or if it needs very extensive revisions.

So I think we need to discuss ongoing revision only after we've heard from the Executive Committee has a whole.

DR. SOX: So Alan, let me understand

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you correctly. Are you saying that we can't act on Bob's proposals until we discuss the document as it currently stands looking at it as an interim document that's going to help us get off the ground in the next 12 months or so?

DR. GARBER: Exactly.

DR. SOX: That certainly seems like a reasonable suggestion. But why don't we see if there are any other comments.

Jeff, did you have your hand up? Leslie?

DR. FRANCIS: I wanted to comment that I think that we should go actually section by section with the idea of whether or not there are things in this document, using it as a general framework, that we think are problematic even on an interim basis. One example might be the implication in the generalizability section to the Medicare population, that the Medicare population is only the elderly.

DR. KANG: Yeah. I would actually agree with that. I think we need some minor tweaks here and more along the line of tone or clarification, and I don't think we're that far apart.

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Listening to the comments, I read this

document in a completely different way than many of the commenters are reading it, and that really suggests that we have somewhat of a problem.

The first is I did not read in this document that there's an implication that everyone has to have a randomized controlled trial. What this document in my mind says is that's the gold standard, but to the extent that you deviate from the gold standard, you have to explain biases, how you dealt with it et cetera.

So clearly a case controlled trial where the biases let's say against device or service or whatever, someone can say well, that's okay. All the biases are against it. That's a good trial.

The second observation I had was the same as Dr. Francis', and this really actually dealt with, I think, the Medicare beneficiary rights testimony and a couple of other testimonies. I think we do have to clarify that the results associated with the study population are the results associated with the study population. Now, it so happens that the study population excluded people under the age of 65,

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and if you want to broaden that coverage, you actually have to deal with whether you can get there or not.

As it turns out, as the doctor with multiple myeloma from Arkansas was saying, if in fact the study didn't have age exclusion but actually had another exclusionary criteria, then the age probably goes away. You just actually write a coverage decision that had the exclusionary criteria.

The whole point, though, is you look at the study population, and you agree with the results. And then to the extent that you want to cover beyond the study population, you actually have to justify why it had reason to do that and explain why that's an okay thing to do.

So I would actually see that those two minor tweaks -- and maybe they're not minor, but

I think what Bob is suggesting is they still require a fair amount of wording, but I think that gets to most of the problems that have actually been identified by the presenters that there are some process problems.

DR. DAVIS: Well, I agree with a lot of the comments that have been made. And to pull

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them together, what I would like to see is I agree with Leslie that a section-by-section review would be appropriate today. We're not going to do all the things that need to be done to the document, but we can do a lot to fix this. So I think a section-by-section review would be good, and then by the end of the day approve it with the fixes that the committee agrees to, and then approve it as work in progress, then give it to the panels as a framework to guide their work in the coming months, and then continue to come back to the document and refine it as necessary, especially considering that when panels begin to use it, that will represent a pilot test, if you will, of how appropriate and practical the document is, but again coming back to it over time refining it as necessary. And also, I'm sure we'll want to take into consideration more detailed comments from the public and from various stakeholders.

DR. SOX: Ron, maybe you could also speak briefly to the concept Bob has advanced about getting public input to this document. To me it's kind of an attractive idea that we would really seek broad input. We would have to make

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the final call on the wording, but it would give us an opportunity to make some changes in tone, and if it seems appropriate to do so, that may be very difficult to accomplish in the short-term.

What do you think of the overall strategy of getting public input?

DR. DAVIS: Well, we've obviously had some already today, we had some before we came here today, and we'll have more later on this

afternoon. So my sense is let's try and improve it today. Maybe we can go section by section and allow people to propose improvements, and maybe those can be approved as we go along by the committee or disapproved, then hear some more public comment from 3:15 to 3:30 or whenever that happens as listed on the agenda, and then leave the final approval by the committee to the end of the day as the agenda indicates. Then there will be more detailed commentary after we adjourn today, and we'll take that into account when we reconvene in a couple of months.

DR. SOX: Other comments about the process? I would like to advance a notion and see how it flies with you. I'm a little worried that we're going to get into wordsmithing over

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tone that's going to kind of bog us down and would like to propose that we try to focus more on technical content and less on tone during our discussion, explicitly recognizing that we're going to get a fair amount of public input hopefully in writing, I would suggest, on how we alter the tone in a useful way.

My guess is that as long as this document continues to be an interim working document in the next few months, these issues of tone probably aren't central to getting on with that work.

Does that feel pretty comfortable to you all that we focus on technical content and recognize we have a process for modifying the tone in response to public comment both here and that we may receive later on? Alan?

DR. GARBER: Well, I want to make sure I understand the implications of what you're proposing. I just know my panel, medical surgery panel, is meeting in a little more than a month, and I suspect that members of my panel won't care much about the tone of the document and will care a great deal about content. And if by technical issues, you mean the content -- that is how are

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you going to evaluate the evidence and so on -- that's great. That's what we need. And I agree the wordsmithing about tone is not going to be the number one concern of our panel.

So if we could end today with the consensus about content as in what are the specific directions that the panels will receive. And let's not forget that although this is a public document, its primary purpose is to guide work for the panels. So that's really what we should be focusing on.

If we can come to some consensus today, that would be extremely helpful to us and I suspect all the other panels.

DR. SOX: Bob, did you want to comment?

DR. BROOK: From a process perspective, I believe that the question we ought to ask the committee, as a guide for the first panel meetings, is there anything you find in the document that's objectionable that would allow you not to want to give this to the panel as guidance for the first meeting?

If we limit ourselves to that question, then I think we could do the task that people

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have talked about, going section through section. If we do anything else, I don't think we're going to succeed.

I think that, however, this is basically not a technical document, but a political document written by a technical group, and I would urge that we view it as such and therefore insist that before we finally approve the document, I think we can say to the panels use it as a guidance for the first thing, that we get absolutely specific written comments from anyone in the public who wants to give it to us with a justification for what they're trying to achieve by that comment so that we can explicitly respond in writing, do the same thing we're asking the panel to do, to explicitly respond in writing why we believe that this word ought to

stay the same, this word ought to change or that we consider this other thing, and then do this as an evolutionary process.

So my concern is do we have enough discipline to hold ourselves for this conversation around the table to say what's in here that really the chair should not use at the first set of panel meetings, not what you think

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about the tone and structure and everything, what we think this eventual document will look like?

DR. SOX: So it's partly objectionable, but it's also unclear and confusing. I mean if you don't understand the document, you can't instruct the panel about problems. We've got to deal with those problems as well. Okay. I think we're all together. Bob?

DR. MURRAY: I'd like to comment that I think it's inevitable that this is a guidance that is titled recommendations. It's filled with words like should, it's expected to, would normally. It's only a guideline. It's not a prescriptive legal statute.

Secondly, it's inevitable that it's going to be treated as such because we have only a month or six weeks before the next panel meeting, and one of the provisions calls for a six-month or anticipates a six-month time line in order to get to the panel meeting. Well, of course, you're not going to squeeze six months' work into six weeks.

My feeling is that we should approve it as is or with minor modifications because it's a guideline. It's a recommendation.

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DR. SOX: I think we're all clear. My suggestion is that we take it section by section and we take a few minutes before starting the discussion for people to go back over and if they haven't already identified concerns, to do so. I'm not sure everybody has a comment.

Have most people already marked it up? Great. In that case we can go right into it.

DR. HOLOHAN: Since we're switching our agenda a little bit, we're going to ask questions or make comments on some of the public statements, there are a couple of things I'd like to comment on before we start just to get them in the public record. The written comments that were supplied are, I presume, in the public record, and I think a few things have to be clarified.

One is HIMA has a statement that says the six months that are suggested in the document is the length of the life cycle of some technologies. I find that very difficult to believe. So it doesn't square with Mr. Roe's interest in people investing money into a -- stent versus medical technology.

Secondly, there's a HIMA statement that

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says technologies have improved laparoscopic cholecystectomy -- would have difficulty in clearing the evidentiary hurdle. Laparoscopic cholecystectomy was actually decided as a coverage issue by Medicare on the basis of the request for review by the U.S. Public Health Service. Their standard, arguably lengthy procedure, that was extant in the early 1990s, and HCFA was able to make a coverage decision in a period of four months. So it's in the public record, but it's not entirely true.

The only other comment I'd like to make, Ms. Gottlich mentioned again VA coverage. I'm perhaps oversensitized to this because it came up four times at our panel discussion on treatment of multiple myeloma.

I think, as the only VA representative here, it's inappropriate to make comparisons between benefits provided by Veterans Health Administration and benefits provided by Medicare for two reasons. The major one is that HCFA's statutory requirements and the VA's statutory requirements are considerably different. The Veterans Administration is required by law to provide clinical care to patients to do research,

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to provide medical education to medical students and house officers and to act as a backup for the Department of Defense, and I think it is misleading to see VA provision of medical care as some kind of a federal imprimatur about safety and effectiveness in part because of the fact that research is part and parcel of what VA does.

The second is that the VA benefits package extends far beyond medical care to things that HCFA doesn't cover, for example, modification of vehicles for patients with spinal cord injury, modification of homes, a much more expansive long-term care program. So I think it's simple to say well, since the VA does provide high-dose chemotherapy and stem cell support for some patients with multiple myeloma, that it's ipso facto or important to VA for the safe and effective therapy, and Medicare, as another federal program, should follow suit. It's deceptively simple, but it's in fact not the case.

DR. SOX: Let's begin. Let me suggest some ground rules that you want comments on elements of the text that seem objectionable as a
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basis for your panel proceeding or the text is so unclear that you feel that you can't proceed, it doesn't give you instructions you can understand.

I'd like to suggest that people who have a problem with it try to identify the problem, if possible propose a solution, and the process for getting agreement is going to be mostly me looking around the room and seeing nods or asking if there's objections. Try not to take votes unless we go into something that's real controversial.

DR. DAVIS: Hal, can I ask a process question?

DR. SOX: Go ahead.

DR. DAVIS: I think what you've just outlined is fine, but I wonder if we go through

it section by section and stick to the issues that you mentioned a few moments ago, and if we have time perhaps we can go back section by section and address tone again if there's time. Would that fit in with what you're trying to do?

DR. SOX: I agree with separating the two, and if we have time, it would be reasonable to address tone. I'm mindful of the fact that

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there may be a few members who are going to have to leave a little early. So I'm hoping we can get done a little bit before it was scheduled for the end of the meeting so we have everybody here at the end. So I qualify it I guess.

MS. RICHNER: On that note I was wondering if it's possible to do process first. I think that's a critical component of what our mandate is here. A lot of this is so theoretical in the sense that we may get bogged down, and I'm very concerned that one of the huge issues is the evidentiary reports, and that whole section is very unclear, and I would love to be able to focus on that first.

DR. SOX: How do other people feel about that?

DR. GARBER: I guess although I think it's very important to get there, I think we should proceed in order. I think that there are two big issues that were raised overall, if I could summarize what the commentators said in the public testimony.

One of them had to do with the impression some had that -- trials would be necessary, and the other issue was timeliness.

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So the first is in the first part of the document, and the second is in the process part of the document. I think we need to get through both, so that will be the responsibility of Hal to get us through this in a timely manner.

DR. SOX: Responsibility on all of us. Jeff?

DR. KANG: Mr. Chairman, if I could just add, as Dr. Hill was suggesting, the process in many ways, a lot of the timing is HCFA's responsibility, and we really have to work out the logistics et cetera. And during the presentation this is the first time I saw the time frame, and I quite frankly think we can do much better. So to the extent that we don't get there, I really just wanted to signal that we will very work very aggressively with the MCAC to speed up the time frames et cetera.

MS. RICHNER: Preparation of the evidentiary reports was another issue as well as the reviewers.

DR. KANG: I think we can do that faster. A lot of that responsibility, quite frankly, falls to HCFA because it's staff preparation. So I just want to send that message

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loud and clear to the extent that we get bogged down. I actually think we should get to the content of guidance. And we are committed to working on the process issue and getting things done faster.

DR. SOX: I think we ought to focus on issues that seem really important to the panel chairs and co-chairs. So perhaps there won't be any comments on the preface since it's not procedural.

DR. BERGTHOLD: I would like to make a suggestion that we consider what we heard from the public today, which I thought was a very good point, and that we put explicitly up front in the preface, even though we all understand that, that this is for the Medicare beneficiaries to better serve them, so something like after the first sentence, provide advice regarding coverage so that Medicare beneficiaries can be better served. I can't make a vote, but if someone else would carry that vote.

DR. SOX: That's a tone thing.

DR. BERGTHOLD: I don't think it's a tone thing. I thought about that really hard. I

think it's a substantive thing that we missed.
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DR. SOX: Anybody have any problem with now saying observing Medicare beneficiaries?
DR. FRANCIS: I'd like to add an invitation to the panels -- this will be on the last paragraph in the preface -- to convey back to us concerns about the document as they work with it.
MS. LAPPALAINEN: Just a matter of helping our typist, when the committee makes a suggestion to modify the document, you can then ask yourself if it's all right. If then the committee agrees that that change is fine, if the person could then dictate slowly, and we can make that change. We don't have to necessarily do a vote for each individual change. We're hoping to have the document modified and that at the end of the day the entire document can be endorsed, if you will. Thank you.
DR. FRANCIS: My suggestion might be you just add the paragraph of the interim document a work in process. We invite panel comments about your impressions of the document and what changes they might recommend to the Executive Committee.
DR. SOX: Let's go down to the next to
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last paragraph. So you want some wording that might go on to have that paragraph, the last sentence, continue to say and in response to suggestions from the panel based on experience, something like that?
DR. FRANCIS: Sure. The Executive committee invites comments from the panels based on their experience with this interim document.
DR. BROOK: Why don't we just say we will modify these recommendations in response to panel feedback and as needed to respond to the HCFA final rule -- in response to feedback from panel members or something like that. We will modify these recommendations as reflected by input from the panelists and as needed in

response from the panel members.
DR. FRANCIS: Alan, are you clear that that's an open invitation to your panel to give us feedback on how it will work?
DR. GARBER: Yes.
DR. SOX: Okay. Any other changes to the preface? No objections? Okay.
Let's go on to Evaluation of Evidence. I'd like to suggest we basically go through it paragraph by paragraph so we're not jumping
.00150
around, and it will make it easier for the person who's trying to make the changes in the permanent record.
Any problems with the first paragraph? The second paragraph?
DR. DAVIS: We're talking about substantive process, right?
DR. SOX: We're talking about objectionable for the basis of panel action or unclear.
DR. DAVIS: Fine.
DR. SOX: So first paragraph? Second paragraph? What about the statement in boldface about the adequacy of the evidence, does that tell you what you need to know?
DR. MURRAY: This is one of the few places where the word must appears, and perhaps this is tone, but in the prior paragraph the word should is used.
Would this be inconsistent to change must to should or must to is expected to? I'm trying to address some of the concerns heard in the comments that this is overly prescriptive.
DR. SOX: Anybody have any problem with substituting should for must? Go ahead, Alan.
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DR. GARBER: Well, I think this is the sine qua non of what panels do. Details are shoulds, but I can't see how a panel will discharge its duty if it does not determine whether the scientific evidence is adequate. So this is one place where I feel the word must is

used advisably.
DR. MURRAY: We must use must? I really don't have any objection to that.
DR. SOX: Any problem with using must here? Other comments on adequacy of the evidence? John?
DR. FERGUSON: Just a comment, and that is that it was my understanding that HCFA wouldn't send anything to the MCAC panels unless they had some pretty good indication that there was enough evidence. Now, that doesn't abrogate the panel's responsibility for judging it, but I think HCFA has said in their previous generation that they would not send things to the panel unless there was some clear evidence base.
DR. SOX: Do you have a wording change suggestion?
DR. FERGUSON: I would say probably in the paragraph before, the quality of the evidence

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from these sources will vary, and the panels should weigh the evidence according to its quality, a portion of that weighing has been done by HCFA prior to sending the request to the panels or something like that.
DR. BROOK: Can we stay away from that? We don't know how HCFA will want to use this process in the future. Why don't we just write a document on what the panel should do, and HCFA can determine what it will do.
DR. KANG: I think that's correct. You can't presume what will happen here.
DR. SOX: That process isn't written down.
DR. KANG: Quite frankly, I think that the, quote, slam dunks, we'll just deal with administratively. And the reality is that on your broad shoulders we'll be getting the plain ones that are somewhat controversial, so I think that we have to be very careful there. I would just encourage you to just go ahead and do what you think is right.
DR. SOX: Anybody here who doesn't find

Alan and Jeff's point compelling?
Other comments on the boldfaced
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adequacy of evidence? Any specific wording
changes? I don't hear them.
So let's move on to the first paragraph
under comment. I'm just going to expect you to
holler.
Let's go on to the second paragraph,
the one that says many forms of evidence.
Third paragraph, when several such
well-designed trials, any changes to this?
How about the next one, the Executive
Committee believes? Jeff?
DR. KANG: I hate to say that this is a
tone also, but we say here in considering the
evidence from any study, whether they're
randomized clinical controlled trials or any
other trials or whatever, you could say the MCAC
now should try to answer these two main
questions.
DR. DAVIS: Where are you?
DR. GARBER: It's the last paragraph
before bias. You want to insert whether
randomized controlled clinical trial or
observational study?
DR. KANG: Or other controlled trials.
DR. GARBER: Or other controlled study?
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DR. KANG: Yeah.
DR. SOX: So it's really any controlled
study. It wouldn't apply to a noncontrolled
study.
DR. KANG: Right. Any controlled study
including randomized controlled trials because
you do want to deal with bias, and even in an RTC
it's possible.
DR. SOX: So the suggested wording is
that after any, we would put any controlled
study, including randomized controlled trials.
MS. RICHNER: What about the issue of
registries again? I think that limits this.
DR. SOX: We speak later on to the

issue of registries without any form of control.
DR. GARBER: Well, there are some changes we might want to make later on, but I think we have to make it clear that registries can be controlled, and they can be uncontrolled, and I have some suggested wording later.
MS. RICHNER: But this wouldn't then negate evaluation of that type of evidence later on?
DR. GARBER: Right.
DR. SOX: If there was a control, then
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it would fall into this.
MS. RICHNER: Okay. I see what you're saying.
DR. BROOK: Jeff, just to be clear, you've made this more limiting than it was before. The purpose by inserting all that nonsense, the purpose of this sentence, was basically to say this is not a rigid restriction. This is a general. And now by stating controlled trials in it, you've made it much more rigid. Study is very vague.
DR. KANG: I agreed with that point, but I was surprised by the comments that we were getting.
DR. SOX: Actually I think there's a logical reason for sticking it in there because the bias to controlled group and intervention group doesn't apply to a noncontrolled study. So in other words, the remark about bias isn't an issue unless you're comparing groups. So I think it makes much more sense.
DR. MAVES: Hal, that may be true, but I again like the way it was worded beforehand because it was more open, and it was broader and less sort of proscriptive. Unless Jeff has a
.00156
good reason for putting it in there.
DR. BROOK: What about this? In considering the evidence from any study, whether randomized or not, the MCAC should try to answer these two main questions. There can be bias in a

randomized trial study. So why don't we say considering the evidence from any study, whether randomized or not.

DR. KANG: That's fine.

MS. RICHNER: Thank you. That's better.

DR. SOX: Is that compromise agreeable with everybody? Okay. Any other comments on that paragraph?

How about the next paragraph, the one that defines effectively bias? Then we have a real long paragraph coming up, many opportunities for finding fault here. Anybody want to make suggestions about how to change this next paragraph on potential sources of bias?

DR. HOLOHAN: The investigators cannot be sure that they have measured all of the ways in which treated patients differ from untreated, do you really want to put in the word measure?

DR. SOX: Can you tell us where that

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is, please.

DR. HOLOHAN: The fourth line down. It's talking about observational studies. The investigators can't be sure that they have measured all the ways --

DR. BROOK: Are you saying measure to assess?

DR. HOLOHAN: Measured implies a quantitative evaluation which may not be possible in many instances.

DR. MAVES: How about considered?

DR. SOX: Alan?

DR. GARBER: The operational issue here is has it been recorded in some way that it can be incorporated into a study design? And to observe is not sufficient. To consider is not sufficient. It has to be recorded. Measure does not necessarily mean quantified in continuous terms. It can mean it's a binary variable. Doesn't necessarily mean quantitative. Measured means observed and recorded.

DR. HOLOHAN: Why don't we just say

observed and recorded.
DR. GARBER: Well, fine. I wouldn't have any objection to that.

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DR. BROOK: That sounds fine. Observed and recorded.
DR. SOX: Great. Other comments on this paragraph?
Now we turn to the one paragraph that starts random allocation of patients. Any objections to this paragraph for lack of clarity?
Then let's go on to the next paragraph, in an observational, nonrandomized study. Remember now we've got to focus on issues that are objectionable for the basis of panel action or unclear. Ron?
DR. DAVIS: I guess some of these comments could address interpretation by panels, so maybe I'll offer this comment which could be tone, could be interpretation.
At the very end where we say clinical trials of treatments for cancers that have an unpredictable natural history, for example, have repeatedly demonstrated that the results of observational studies are misleading, I wonder if we should say are often misleading.
DR. SOX: Yeah. They aren't always. Fair?
DR. BROOK: It's not that they're

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misleading. They're overly optimistic of the value of the therapy.
DR. SOX: How about frequently overestimate the size of the treatment effect?
DR. BROOK: That would be better.
DR. SOX: The results of observational studies frequently overestimate the size of the treatment effect, and delete often misleading, and go back to the --
DR. BROOK: Remove repeatedly at the first part of that sentence.
DR. SOX: One more wordsmithing change in that sentence, repeatedly on the left hand

side, delete that. Okay. Good.
Next paragraph, to detect important bias. This one has a lot of operational implications. Does it really do it for you? Okay.
Next paragraph, although a body of evidence.
DR. HOLOHAN: Can I suggest that the phrase is never adequate be clarified a little bit? And I think what was meant by the subcommittee was that it would never reach to the reliability of a probably done randomized
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controlled trial, but not that it is ipso facto inadequate.
DR. SOX: Alan, do you want to respond?
DR. GARBER: Well, I realize this is not a flash point, and I think we should be -- the issue here that is I believe perhaps a semantic one -- I'm not certain -- and that is what do we mean by uncontrolled? And from hearing the comments today, I think that some of the people may have been under the impression that what was meant by uncontrolled is not randomized controlled, and that's not the case.
And I actually got some suggested rewording, and I don't know if this will do it. And Tom, I particularly appreciate your opinion about this. That is the first sentence of the paragraph would begin although they do not have randomized controls, all well-designed observational studies include some form of control. They may consist of an implicit or explicit controlled group or statistical controls, that body of evidence consisting only of uncontrolled studies. And I think that's intended to make it clear that registries are probably assigned observational analyses,
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probably assigned controls, and the issue truly uncontrolled study, I think it's strictly true. If it is uncontrolled, it is not valid evidence by itself, yet there are plenty of studies that

could have valid controls that are not randomized, and I would hate for the readers of this document to think that this paragraphs means you have to have randomized controlled trials.

In fact, I was struck that some of the public comments seem to suggest that this document meant only randomized controls would be suitable. We put a great deal of effort on the part of the subcommittee to try to make it clear that observational data would often be -- well, at least would sometimes be adequate, and it really depends on the characteristics of the studies that were being done.

MS. RICHNER: I still think that's missing the mark in a sense because I think why this is so controversial in a sense is that once again when you're looking at the technology curve when you have very little evidence in the very beginning of adoption, it's rare that you're going to have the kind of rigorous studies that you're interested in. So I think what this does

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is we want to make sure that you're looking at the composite of all possible data that's available. And this doesn't allow that. Essentially looking at perhaps unpublished data that might be available that would be interesting, case studies, et cetera, et cetera, and somehow this tone of this paragraph limits all of that.

DR. SOX: We've got to have something to vote on and some wording to vote on.

MS. RICHNER: And unfortunately I had wording that I sent to you that I thought was appropriate on e-mail that would have addressed that as well. Unfortunately my computer has now just died.

DR. BROOK: Can I suggest some wording? I want to suggest an alternative wording before we vote.

DR. SOX: I'm thinking that maybe what we need to do is to get -- this is a really an important issue, and that perhaps an approach

would be that we delay the vote on this. We can move on without this. Each of you submit your wording that we get it up there and we actually wordsmith out.

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DR. BROOK: Can I suggest an approach to this background before we do that? I would like to suggest that we're limiting everything up to in some cases, and we start by saying in most cases given the current state of scientific evidence, panels will determine that well-collected observational evidence -- and then I think we ought to list in there what we mean by that -- will be sufficient to draw conclusions about effectiveness, and I think that that's the tone you want in this paragraph.

MS. RICHNER: Yes, that's much better.

DR. BROOK: Because with a large part of the technologies, that's what's going to happen. So that's how I would alter that paragraph. And I would then spell out in detail what we think are well-controlled observational kinds of studies, registries with historical controls, quasi experimental designs, et cetera, et cetera. And I think I'd even add the point that Jeff came up with. This would be especially true when we have breakthrough technologies and technologies dealing with people with severe diseases with no other recourse.

DR. KANG: That's good.

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DR. BROOK: I think that's what the panels are going to do, and I think we might want to say it.

DR. KANG: May I make a suggestion since we're almost at lunch? I don't think we're that far apart. It actually strikes me that maybe Bob, Alan and Randel sit down at lunch and hack it out. I hate to infringe on your lunch period.

DR. SOX: I think that's actually a very good suggestion. We'll appoint a committee of three, and if any member of that committee is

not satisfied with what you come up with, then that person will submit an alternative, and we can vote on it. Does that sound reasonable? We've got about five minutes to 12:00. Should we give ourselves a break at this point? And we'll come back at 1:00 and continue the process.

(Whereupon, recess taken -- 11:55 a.m.)

(Whereupon, after recess -- 1:10 p.m.)

DR. SOX: Alan, do you have a report of the work group of the subcommittee?

DR. GARBER: We weren't able to locate one of the members of our subcommittee. Randel and I went over some language that I think we

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agree on. So if I could read that to the committee and the audience.

DR. SOX: Should we perhaps have it --

DR. GARBER: Let me read it once first because there's a lot of changes. Okay. This refers to the bottom of that page. It's right above the subheading external validity, the last paragraph, and it currently starts although a body of evidence.

The new language is as follows. Although if they do not have randomized controls, all well-designed observational studies include some form of control. Controls may consist of an implicit or explicit controlled group or statistical controls. A body of evidence consisting solely of studies with no controls whatsoever, whether based on anecdotal evidence, testimonies or case series, is never adequate. And then the last sentence reads, now that there's a change in the last part, when these circumstances apply, the panel must describe possible sources of bias and explain the basis for its decision that bias does not account for the results.

Randel, does that reflect what we

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said?

MS. RICHNER: Yeah. The key issue here is that any of the case series studies or

composite of any of those sort of testimonials, anecdotal studies combined, can never constitute the proper evidence if it's only those types of studies.

DR. GARBER: Only studies without controls.

MS. RICHNER: Right. Without some type of control. So even in an observational study, you can use a statistical methodology in which to observe or have a control as part of that. And that works. What do you think, Bob?

DR. BROOK: My fault. I didn't go to lunch, so I couldn't find you guys. So my fault.

DR. FERGUSON: Can that be written down and circulated?

DR. GARBER: I just wanted to get it done in general first.

DR. BROOK: In general terms I don't believe a document ought to ever use the word never.

MS. RICHNER: Then never is a problem.

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I still don't like the never.

DR. BROOK: There is not a single testimonial that couldn't be put into historical context by some historian. Whether you choose to do it or not makes it adequate or inadequate, but there is no case series that could not be put in some historical context no matter how bad. And the panels are going to be left to judge how much effort and how good these controlled efforts have been. That's why I would have simplified this just to say -- I mean that's their job in terms of what's going on. That's okay. It's my fault, as I said, for not being there.

DR. SOX: Okay. Alan, do you want to read that one more time? Then we can have discussion of it and maybe start to get it on the document as well.

DR. GARBER: Should I read this line up to it? Insert at the beginning of the paragraph the following.

DR. BERGTHOLD: No. She's just going to type it separately for now.
DR. GARBER: Oh, okay. Fine. Although they do not have randomized controls, all well-designed observational studies include some form
.00168
of control. Controls may consist of an implicit or explicit controlled group or statistical controls. And then the next up is -- do you want to just retype the remainder of the paragraph?
THE TYPIST: Would that be here at the end?
DR. GARBER: It goes to the although. It's now the next sentence. The word although is struck and then a body of evidence. So you struck that. The body of evidence consisting solely, and then strike only, and then strike uncontrolled. And then after studies insert with no controls whatsoever. And then after case series strike and disease registries without adequate historical controls. Then it stays the same is never adequate. And then insert however before in. This is something I didn't mention that we changed also. Strike some and replace it with many. In many cases. Then it goes to the last part of the paragraph. Strike why it decided and insert the basis for its decision.
MS. RICHNER: Bob, you certainly still have a chance to comment.
DR. SOX: Well, it's time for comments or questions. Actually I have a question.
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Statistical controls, could you explain what that means?
DR. GARBER: In other words, it's an observational study where they can collect data on a number of variables and basically look at patterns of outcomes, how they're explained by things like say age et cetera. That can be a form of statistical control.
DR. SOX: Is that multivariant analysis essentially?
DR. GARBER: Yes.

DR. KANG: This is different or the same? You do multivariant plus sensitivity analysis?

MS. RICHNER: I actually have some literature that is very recent from the pharmaceutical industry of which they do this type of methodology. And once again, I can't articulate it well, but there are methods to do this in using observational data that is well-grounded. I mean McMasters has done a lot of work at that.

DR. KANG: Could you take another attempt at trying to explain to me?

DR. GARBER: Let me tell you about some

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of the work we've done using Medicare claims files. Let's say that you want to have an idea of whether revascularization in post MI improves outcomes. You can take Medicare claims files which have extensive information about discharged diagnoses, age, location and a number of other individual characteristics, and there are various statistical methods you can use to determine whether the people who have treated with revascularization did better. So you'll have Bob Brook saying that's all very hokey, but that's what statistical controls are, and the panels have to decide whether this type of evidence is adequate or not.

DR. HOLOHAN: It's retrospective.

DR. GARBER: Well, it's actually historical prospective. The point is we're not going to determine right now whether any particular study in science is adequate. The point is that there are methods, and there are cases where you can use that kind of a controlled group -- that is implicit statistical control -- to draw conclusions. The panels may decide yes, this is convincing or they may decide it's not on a case-by-case basis.

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DR. SOX: Any other questions or comments about this? Ron?

DR. DAVIS: Well, I like it. I just wanted to suggest one other small change at the end. Instead of saying that bias does not account for the results, to say that bias is unlikely to account for the results. I think the panel would more likely say we don't think bias accounts for the results. I don't think they'd say bias does not account for the results.

DR. SOX: Does that sound reasonable to you guys?

MS. RICHNER: We had that discussion as well. Are you comfortable with that?

DR. GARBER: Yeah, I think that's fine.

DR. SOX: Any other comments? So it goes. We now go on to external validity, first paragraph.

DR. FRANCIS: There's a replacement effort.

DR. KANG: If you don't mind, Dr. Francis and I, in going through it ourselves as a group of two, took another crack at this. So this is under external validity. And maybe we'll

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read it.

DR. SOX: Is this suggested as a substitute for the paragraph?

DR. FRANCIS: Yeah. For the first paragraph.

MS. LAPPALAINEN: I'll read it out loud. Issues of external validity related to the study of population. Medicare beneficiaries include elderly, nonelderly, and disabled people. The Medicare population also may or may not include patients with comorbid disease. That said, historically many controlled trials unfortunately excluded older men and women, people with disabilities and people with comorbid disease. This means that even when a trial has adequate statistical power for the study population, that its results may or may not be generalizable to some portions or all of the Medicare population. If the requester is asking

for, or the panel is advising, coverage beyond the clinical and demographic characteristics of the study population, the panel should state that they believe the results of the trials are applicable to a broader population, define what that population is and explain its reasoning
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why.

DR. SOX: So Leslie and Jeff, perhaps you could explain what lead you to make this change so we all understand what's behind it.

DR. FRANCIS: One thing that was behind it was the recognition that Medicare population is not just the elderly. And at least the way the myeloma panel was set up, the question that was posed to the panel was we've got a lot of data in there under 65s. Can we extrapolate from 65s and over? And we wanted to take away any implication that that's the way stuff should be set up rather than focus on the question of what were the inclusion and exclusion criteria in studies and what that says about what are all portions of the management population coverage recommendations we are aiming for. So that's what we're trying, however inartfully, to capture.

DR. KANG: Part of the problem with the tone of this paragraph is it assumes that all Medicare coverage decisions are for the general population. We are now -- practically all of our coverage decisions are limited in some way, have exclusion criteria or inclusion criteria, and a
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lot of times we do it for the study population. That is something, quite frankly, that's been new.

So I really think the issue here is is it a statistically valid study population -- then a request is for that study population. And we should cover for that study population. And if it so happens we only have three beneficiaries, that's okay. It's still covered for those three beneficiaries. That's more or less what we were

trying to get to.
DR. GARBER: Well, Jeff, I guess you correctly guess that my concern is the last part of this.
DR. KANG: That's correct.
DR. GARBER: And the problem is probably semantic, but as I read this revision, it could be applicable to a broader population, but it doesn't necessarily mean it could pass that criterion and still not necessarily be applicable to any defined population of Medicare beneficiaries. So the original language -- I mean I completely agree with the intent of this and with the rest of it, but the original language, just to remind people, is if the study

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population in the available trials is not the same as the general population of Medicare beneficiaries who would be candidates to receive the intervention, the panel must state whether the results of the trials apply to typical Medicare patients and explain its reasoning.
And that language was really saying does this generalize to the relevant population of beneficiaries? And I'm not sure the language that you proposed at the end actually gets at that. So I would propose something like an amendment to the original language for the last part, and instead of saying typical Medicare patients, maybe two defined populations of Medicare beneficiaries so you cover ESRD, disabled et cetera.
DR. BROOK: Can I suggest changing broader population to the results of the trial applicable to any group of patients covered by Medicare? So that would then allow you total flexibility since we're writing this for Medicare.
MS. RICHNER: Results in the study too rather than trials.
DR. BROOK: The results of the trials

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are applicable to any population covered by

Medicare or can be applied to any population covered by Medicare. Define what the Medicare population is and explain its reasonings why or what part of the Medicare population it applies to and explain its reasonings why.

DR. KANG: I'm not sure that gets it. I'm okay with it.

DR. GARBER: I like my wording better, which is defined populations of Medicare beneficiaries so you can say this is effective for ESRD beneficiaries, and this is effective for elderly Medicare beneficiaries, and this is for the disabled. But the point is that the panel should explicitly say which population of beneficiaries if any they believe the results of these trials apply to.

DR. SOX: Alan, are you proposing we go back to the wording of that last sentence?

DR. KANG: Alan, I'm not sure I understand that because we actually -- our coverage decisions are now running like this is effective for ESRD patients who don't have heart failure or whatever it is.

DR. GARBER: That's what we're saying,

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that the panel should say what the trials apply to, some population like that. Now, you could tell us look, we'll decide. We don't want the panels to get in the business of determining whether the trials apply to populations of beneficiaries. I think you'd be better off using panels to try and evaluate the evidence and see whether they think they can extrapolate from the trials to some population of interest to Medicare.

DR. FRANCIS: Why don't we just change the last sentence to say to populations or to groups covered by Medicare, define what those groups are, and explain the reason why.

DR. GARBER: Could you say the exact words?

DR. FRANCIS: Believe the results of the trials are applicable to some groups covered

by Medicare, define what those groups are and explain its reasons why.

DR. BROOK: Define it in clinical terms if you want to.

DR. GARBER: No. I think that's fine.

DR. BERGTHOLD: Does that allow Medicare to make, sort of, fine, sort of,

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distinctions within those populations though? Because that almost sounds like if you're an ESRD person, you get this treatment even if you do have heart failure or whatever. No? That doesn't mean that?

DR. BROOK: No.

DR. KANG: No.

MS. RICHNER: The other question I would have here about define it in terms of just trials, wouldn't you want to make it a little broader in terms of studies? Because the whole part before was describing we're going to be looking at lots of different kinds of evidence, so therefore we don't want to limit ourselves to trials here.

DR. KANG: I was concerned this study has to be statistically -- so you could say --

MS. RICHNER: Well, yes, but that's covered in the part before.

DR. KANG: Okay.

DR. HILL: I don't think you meant, Leslie, to say that if the requester is asking, the panel should state. That first phrase is in the alternative. You only mean if they agree.

DR. FRANCIS: Right.

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DR. HILL: So you state whether or not they believe.

DR. FRANCIS: Whether they believe.

DR. HILL: This way it's grammatically, if the requester asks, that they are being requested by you to state that they believe.

DR. FRANCIS: No. They should state whether they believe.

DR. FERGUSON: I have a question. Is

it true that the sentence that says the study population results may or may not be generalized -- wait a minute. If the requester is asking for, or the panel is advising, coverage, is HCFA comfortable with our panel's advising coverage? Are coverage questions going to be asked specifically?

DR. HILL: We've answered that as we've gone along and repeatedly said that we understand we have the responsibility for deciding coverage. So I take that to mean if you want to clean that language up, I'd be grateful, but I don't want to slow you down.

DR. FERGUSON: Safe and effective or some other words.

DR. KANG: See, this is tough because

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by our federal register notice we are asking the requester to specify the population that they're seeking coverage for. We get that with varying degrees of success.

Maybe one of the ways we do that is to clean that up and really demand, before it gets to the panel, that they are very clear about what population they're looking for. Then the panel's decision is whether or not the evidence supports that.

The only thing that we get into somewhat of a problem is if it doesn't support it, then there's the question of well, what would it support?

DR. FERGUSON: But advising coverage and advising that the evidence supports coverage might be --

DR. HILL: May I suggest if the requester is asking for coverage or the panel concludes that medical benefit can be --

DR. SOX: I'd like to suggest -- I think we know what we're going to say here. Rather than try to wordsmith this thing in detail, I'd like to suggest that we take it down and somebody work on some language that doesn't

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have us recommending coverage, but still allows the requester to request coverage. I think we know what we want to say.

DR. KANG: I think, John, advising support for will be okay. Let's just get it over with.

MS. RICHNER: And the other part about trials versus studies.

DR. KANG: We took care of that.

DR. BERGTHOLD: It doesn't apply above.

MS. RICHNER: That sentence, historically many controlled trials unfortunately --

DR. GARBER: Yeah. But that's true. It's much more common trials and observational studies to --

MS. RICHNER: Okay. I see what you're saying.

DR. KANG: That's correct. That's the ages within our society.

DR. SOX: I'd like to turn it over to a wordsmith to clean it up a little bit and make sure we're happy with the wording. Who would like to volunteer to be the wordsmith? Ron?

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DR. KANG: I want to make sure you're okay with it. I don't think this violates your original intent.

DR. GARBER: I think it's probably fine. It's certainly not worth struggling over.

DR. SOX: Okay. Let's move on. We'll give this to Ron, he'll work on it, and we'll move on to issues of external validity also apply to the intervention. Any objections or clarifications required here?

MS. RICHNER: This paragraph we also discussed at lunch briefly. One of the issues here -- and I don't know if this example is the appropriate example in here. I mean I guess we can go ahead and use it, but I'm concerned about the interpretation of this. Certainly, once again, the technology, this skill of the surgeon

over time improves, and the outcomes associated with time improve as well. But once again, this is an example of external validity.

DR. SOX: Gets over the concept I think.

MS. RICHNER: Yeah, I think we're okay.

DR. SOX: Any other questions about this one?

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DR. SMITH: I guess now that we have somewhat talked about the elderly and nonelderly and disabled, I guess my concern is I read where you have like demographics. Have we lost or does that encompass let's say racial and ethnic inclusions or should there be, can there be, some consideration given to that particular area?

DR. SOX: Are you talking about --

DR. KANG: She's talking about the previous.

DR. SOX: -- the previous paragraph?

DR. SMITH: The previous one. I mean it seems as if it's getting lost.

DR. KANG: Yeah. I think the reason why -- and I'm not sure I'm aware of a trial with racial exclusion, but I could be completely wrong on this. But I would not have any problems, I don't think, adding racial inclusion to the extent that it occurs.

DR. SMITH: I thought about it. It may even be something that could be stated in the preface rather than just in one specific area, and then that automatically would speak to it with some consistency throughout the document.

DR. KANG: Actually this would be the

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place to deal with it I think.

DR. SOX: We need specific wording suggestions. Daisy, do you want to take a look at this paragraph after Ron gets done with it and suggest some language? Not all of us completely understand.

DR. SMITH: So when you have concerns, you just keep quiet, right?

DR. SOX: No. We need something to look at so we know whether we like it or not.

DR. HOLOHAN: Just as an editorial comment, the best example I can think of recently of a trial that was dramatically racially imbalanced are the studies of -- and hepatitis C patients. The patients tested do not represent the population of patients with hepatitic C in the United States today.

DR. KANG: So then probably we should add it along, and that would be the easiest way to deal with it.

DR. GARBER: Just to make maybe a substantive point because there will be a lot of interested parties here, we don't intend to imply that every study has to have adequate sample sizes of various ethnic groups and so on to draw

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conclusions. Just the panel needs to decide whether they think the results of the studies apply to those populations. We don't want to send a message gee, you're going to have to have an adequate number of Hispanics, adequate number of Asian Americans and so on. That would be impossible.

MS. RICHNER: As a matter of fact, there's one more point I wanted to make about this, and that's foreign data. I don't know how you're going to address that, but certainly there are many studies that are done outside the U.S. And how does that apply to Medicare populations? And in turn, we run across this all the time. The FDA now accepts foreign data. So that is going to be an issue associated with this as well.

DR. KANG: By this language we're not excluding foreign. This language says if it's foreign, then say that I believe this is generalizable to the American population for these reasons.

MS. RICHNER: As long as we're talking about methodology and study design, et cetera, and evidence.

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DR. HOLOHAN: The issue is can the panels extrapolate?
DR. FRANCIS: One of the things that was very striking about the myeloma discussions was that although the incidence of the disease is much higher in African-Americans, the actual apparent access to the therapy in the testimony of the patients, who were all white, there were obvious issues of access that underlay the whole discussion, and I wonder whether there's a way to go back to the preface and put in something about equity and the importance of equity in the coverage process.
DR. SOX: Is that something that we could deal with after today and still operate as --
DR. KANG: We can.
DR. SOX: I want to move on now to Size of Health Effect. Any problems with the way that is stated?
DR. FRANCIS: I have a clarification and a question. The clarification is I want to be sure that category 2, more effective --
DR. SOX: You're getting ahead of us. We're going paragraph by paragraph. First, just
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the stuff that's in boldface. Any problems with that? John?
DR. FERGUSON: Must we have must instead of should?
DR. GARBER: Yeah. Because I think we're saying there's going to be a standardized way of reporting. Each panel reports the evidence into these same set of seven categories. And if there's any reason these seven categories aren't right, we should probably change the categories now rather than saying should.
MS. RICHNER: Well, there was a suggestion by the audience for an additional category that was from one of the letters. Not only that, I remember in our conference call that we had David Eddy suggested that there were

perhaps 15 different categories. So I think we do have to think carefully.

DR. FERGUSON: I withdraw my comment because I think what you're saying is the comparison is the must, and that's clear.

DR. SOX: Okay. So we've dealt with the stuff in boldface. Now let's go on to the first part of the comment, just that first couple of sentences. Then we'll go through the seven

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categories. No problems? Then let's go to the seven categories.

I'd like to suggest that modifying these may be the sort of thing that we do after we have a chance to use them a little bit, and we may find that these categories need to be expanded in order to deal with circumstances that will come up only when we actually do a study and try to classify its effect size and find we really can't do it properly. It may work better than trying to wordsmith these categories or at least change significantly the categories right now. John?

DR. FERGUSON: Just a comment. And I'm sort of asking this. One of the advantages might be cost, something would cost less. And maybe we shouldn't put that in there, but it's certainly something that I would hope we sometimes are presented with as an advantage. Is that a no no? Can we list that as an example?

DR. SOX: Basically it's a no no.

DR. KANG: For the time being.

DR. FRANCIS: Can I just ask you about category 2? Does that include small benefits for lots of people as well as relatively significant

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benefits for small numbers, but we don't know how to sort those out into identifiable subsets?

DR. SOX: Alan, do you want to respond?

DR. GARBER: The question comes down to whether they are prospectively identifiable categories of people who get substantial benefit. If they are identifiable, I would have

interpreted this to mean they go in category 1 and category 2 for the other groups. And if they aren't identifiable, it's irrelevant. There's always some people who will benefit, but you don't have any way to sort them. You just have to go with the average benefit.

So the question is can you identify a category with greater benefit? Obviously if you give an intervention that's slightly better, what that usually means is that there's some people like you're measuring mortality, more people live, but you don't know for sure who's who. That's what subgroup analysis --

So the other just quick comment, the ACP-ASIM talked about more objective, but some disadvantages. I think that we discussed that in the conference call, and that would have gone into category 2. So what they're talking about

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is subdividing category 2. And the subcommittee was trying to get the smallest number of categories that we thought would do a good job of classifying people. So it's up to the Executive Committee whether you think that should be expanded or not.

DR. SOX: I think we also want to get a sense from HCFA about whether those categories are likely to be beneficial to them in trying to make coverage decisions. That's certainly the principle purpose of this system of categories.

DR. KANG: I actually think it would be helpful, yeah. I mean obviously this is the place, quite frankly, where our final coverage criteria will interact, but at this point I think the better strategy is to go for more categories, whatever we can think of, and then to the extent that we're collapsing categories in the future --

DR. SOX: Debbie Zarin made the suggestion we've really got a three by three matrix for everything except for the breakthrough technologies, which would basically include every possible combination of effective on the three-point scale and advantages, no advantages or

disadvantages. So maybe we should simply use
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that and then collapse those categories if you find they're not useful. Alan?

DR. GARBER: I guess my experience regarding the technologies per Blue Cross Blue Shield is that the vast majority of technologies have some advantages and some disadvantages, and I think that we would be telling the angels how to repent if we tried to decide whether or not they were more or less advantageous. I mean some of these technologies have fewer side effects for the initial treatment, shorter duration of benefit. Some have greater convenience, but less effectiveness. And sometimes they trade off one side effect for another. So I like our original classification because I thought this classification keeps us from spending too much time pondering the imponderable.

DR. KANG: I'm going to withdraw. I've run into the same problems and gotten paralyzed from inaction. So I like this just fine.

DR. SOX: We could in our explanation say why we put it in a particular category and actually list any factors that led us to do that, and that might be more valuable to you than the category itself for making a judgment.

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DR. KANG: I think that's correct.

DR. SOX: Randel?

MS. RICHNER: I wanted to ask the overall panel if anyone has any concerns about how to identify what the established service and medical item is that you're going to be comparing the technology to or the item to. Is that going to be an issue? That's a question I have for everyone. We've talked about that at length in the subcommittee about what an established medical service or item is and how do you determine what that is. Is that going to be an issue?

DR. HOLOHAN: Can you be more explicit in what you mean by how do you determine --

MS. RICHNER: What's usual care, what's usual practice. How are you going to decide that this technology -- what are you comparing it to for benchmarking this?
DR. HOLOHAN: You mean the term established services?
MS. RICHNER: Right.
DR. SOX: Originally we had it already covered, and we thought that would be too limiting.

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MS. RICHNER: It is.
DR. KANG: Having thought about this problem a lot, I would actually suggest we're not going to be able to resolve this one today. I think that we ought to wrestle with this as we go on and refine this one. This really is a tough question.
MS. RICHNER: It's a tough question, but I think that the tumor assay issue sort of stems from all of that in terms of what is the comparison and what is the benchmark?
DR. SOX: I wonder whether it will vary from instance to instance. And part of this series of things that you do during that first month when you're trying to get the chart set up is to decide what the comparison technology is going to be.
DR. KANG: This is actually why Dr. Hill referred to sector-specific guidance documents. The reality is this is best addressed by the panels almost because this is going to vary from the sector that your talking about. Maybe we could indicate that the panel can at least in their context think about what the comparisons ought to be. But this at this level

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is not a solvable problem.
DR. SOX: Or the panel chair in collaboration with HCFA staff is setting up the charts. So I think Jeff has withdrawn his proposal that we expand the number of categories, and we can probably take that matrix down for

now. So we're still at 7, and we're going to stay with established.

Are there any other comments about the categories before we move on?

Hearing none, we'll move on to Suggestions for Panel Operations. The first one is Explanation, A panel must explain its conclusions in writing. I think the basic reason for this, the rationale is pretty clear, probably not likely to cause much push back, but maybe the implementation is an issue.

DR. FERGUSON: A comment, and I'm not sure how the wording needs to be changed, but the panel's conclusions will still be established by voting; is that correct?

DR. SOX: That's correct.

DR. FERGUSON: Those who oppose a motion are supposed to say why. Those who vote yes, they presumably don't have to do that; is

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that correct, don't have to say why they're voting yes?

MS. LAPPALAINEN: Right. The individual panel chair has the discretion at each panel meeting to go round robin after the vote is taken. Generally a no will invoke a question of why you said no in order to make sure that any minority response gets to the record. And the other is, of course, the majority of the vote. But this does not preclude the members from expressing their opinion or even a dissension in writing.

DR. FERGUSON: Okay. So then the panel chair is responsible for summarizing the thought that went into the yes or no votes I guess.

And again, it's a common question, how to handle it. Maybe in case the panel chair, who does not vote unless there's a tie, would be responsible for writing this conclusion, and I might disagree with the conclusion, which has already happened once --

DR. SOX: It's the panel chair's responsibility to write the conclusion that

reflects the majority regardless of his or her own preference.

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DR. KANG: Or, John, you could delegate to a majority. I mean it's really at your discretion.

DR. SOX: I would hope that panel chair is capable of writing a strong piece on something they disagree with. That's part of the job.

DR. DAVIS: I wanted to propose a change on this last sentence which picks up on this issue we're discussing. I wanted to suggest that we change it as follows. The panel chair is responsible for drafting the explanation of the panel's conclusions, which should be circulated to panel members for their comments and/or approval. I just don't think it should be solely in the hands of the chair without the opportunity of the panel members to see it.

DR. SOX: Sharon, did you want to say something?

MS. LAPPALAINEN: I just wanted to clarify something. A summary of what happened at the panel meeting is required by the Federal Advisory Committee Act. That summary is certified to by the executive secretary and the panel chair. That is a legal requirement that we will continue to do, and this is in addition to

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that.

DR. SOX: Alan?

DR. GARBER: Well, I think Ron's suggestion kind of comes down to what this report of the conclusions is supposed to be in, and I guess in the course of our subcommittee's deliberations I had in mind saying it's going to be much more rapid, something like a one-page document that is approved at the time of the meeting.

I think we have to be very sensitive to the ways that we might unintentionally create in this process, and I thought we should be brief and very rapid in summarizing the results of the

meeting so that the panel can in real time approve the chairman's summary of the conclusions and the reasoning for the conclusions.

I think in most cases this is only a summary. It does not have to be an exhaustive review of what happened at the meeting because after all, transcripts will be available and the other materials that Sharon was talking about. So I had in mind something like a one-page report that is done at the meeting and wrapped up.

MS. RICHNER: But that's not clear.

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DR. GARBER: I agree. So I guess Ron has a much clearer way of stating the one model, which is a longer process, but my intent had been we do something in real time.

DR. SOX: I like Ron's approach better because I think it's very difficult to write a one-pager that is really good on the fly. Maybe you can, Alan, but most of us can't.

And the alternative would be to require the panel chair to write it, get it out for comment, and if you don't hear from somebody in 48 hours, then you would assume to send and have a requirement basically that it be back in HCFA's hand in a week. That would give a little bit more time to advise carefully and would give an opportunity for thoughtful review of what's been written. And I would think of it not so much as approval, but comment. And ultimately it's the responsibility of the chair to, in a just and fair way, take into account comments. So that's, I guess, more an attempt to telescope it out in the interest of clarity.

DR. GARBER: Can I make a proposal that we approach with discretion and collect some experience? Because it sounds like we're

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planning to adopt different approaches.

DR. SOX: But I think we ought to have a sense of the group. Something ought to be back in HCFA's hands in ten days.

MS. RICHNER: It went from 48 hours to

seven days to ten days. That's too long.

DR. SOX: Does a week seem reasonable to get this done?

DR. GARBER: My concern is that there are discrepancies in the comments. There's no problem if the only differences are points of clarification where there's no disagreement. But as we've seen in some of these issues, there can be considerable disagreement. And if you as the panel have to adjudicate between two members that say directly contradictory things, it's very hard to resolve that without having a conference call or face-to-face meeting. And I assume things really have to be public.

MS. LAPPALAINEN: Presumably that would fall under an operational aspect because we had the public meeting, and the public transcripts are available. The putting together of this document would be operational, so we could have another meeting to talk about the route.

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DR. KANG: I actually have to agree with Alan. While I'm sensitive to actually Daisy's concerns, we do want to try and make sure that the process does not slow down. I think forcing a summary at the end actually forces people to agree on what they can agree on and disagree on what they can disagree on and actually get it up there. The transcripts are available to HCFA and its staff, and the whole richness of the discussion is available. And quite frankly, we would factor that in and look at that also and look at the summaries together. So I think forcing the summary before you go home is the way to go.

DR. SOX: Any other comments?

DR. BROOK: I can tell you what's going to happen here. People will reach agreement and have very different reasons why they got there. And the chair will only figure out what he thought he heard, and it will not be what each of the individual panel members voted yes or the majority opinion agreed. So we are stuck with

either the panel chair trying to summarize the evidence saying they voted already and to summarize the reason for it or to ask each member
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of the panel before they go home to write a one-pager in support of their position, which then would be the summary.

Instead of having this long transcript, you could have a situation where the panel chair is not responsible for summary, but each person who votes is responsible for defending their vote yes or no, and therefore, that would be part of the evidence that goes with the vote. And nobody would try to reconcile that this person believed this because he liked that study, and this person believed this because that person wore a green tie, and this person believed this because they were tuned out and daydreaming.

I mean it would motivate each panelist to pay a little bit more attention -- I think everyone would anyway -- but to pay a little more attention to the process if they knew at the end of it they would have to justify their vote.

So I would change this to say that not only would this thing be voted on, but each panelist is responsible for explaining in writing at the panel's conclusion their individual vote.

DR. BERGTHOLD: There are seven questions sometimes or ten to answer, Bob, and
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that means that's a lot of stuff to write.

MS. RICHNER: I'm thinking of the FDA advisory panel process. I mean it's been awhile since I've been there, but you decide that day, and you give your vote, and you say your explanation as to why you gave your vote, and it's on the transcripts, everybody knows it, you can use that data later on, and you don't leave that room until that's finished.

Sharon, correct me, but that's what I remember.

MS. LAPPALAINEN: You're right. The FDA process is as follows. Any primary reviewers

that are assigned to review prior to the panel meeting, those written recommendations are part of the administrative file for the particular matter in front of the committee. At the advisory committee transcripts are taken, summaries are written and certified to. Panelists will often think about what happened at the panel, and subsequent to the panel meeting, will send to FDA in writing, if they feel compelled to do so, or if they feel that they had a minority opinion that was not properly brought forward. Those things that are in writing are

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also part of the administrative record of what happened at the panel.

DR. SOX: Our goals here, I think, are twofold, mostly to serve HCFA's needs, and secondly, to turn out a product that you can understand and reads well. And it seems to me that going around the room and explaining your vote really deals with Bob's issue, puts that on the record for HCFA to look at and say whoa, actually this person has a point, we'll do it this way instead of that way. So I think it deals pretty well with that issue.

I'm still, frankly, troubled, Jeff, with whether you're going to get the really good prose that you want to put on the Internet from trying to do it at the end of a long afternoon, but we'll try it and see how it goes the best.

DR. KANG: Sharon, I'm not familiar with the FDA process. On the FDA panels do they actually try to do what Alan is suggesting with the one page?

MS. LAPPALAINEN: Well, if I can have a long response, the FDA asks particular questions regarding particular matters that come in front of the committee, and the panelists generally go

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round robin on those questions during the open committee deliberation. However, the vote for either premarket approval in the device world or new drug application in the drug world or

licensing application in the biologics world is actually approved. And the panel has three choices, to approve, to approve upon a condition or to not approve. And so the ultimate vote is really only on that issue and not the individual questions.

DR. SOX: Bob?

DR. MURRAY: I'm a bit concerned about trying to do it too quickly or in too frank a fashion. Several points.

Number one, if the purpose is to form a body of case law, then it has to be reasoned and organized, and I think doing it on a very short deadline before you leave in the afternoon would not serve that purpose.

Secondly, I don't think it would serve the purpose of giving a concise, logical document to be used by other committees, by other panels or by the same panel subsequently, if instead of a single document, you had 10 or 15 separate opinions each scribbled hastily.

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And thirdly, if I were assigned to write the summary, I would like to look at the transcript because I would not want my summary, the words I use in my summary, to come back to haunt me if at a later meeting somebody had the transcript and were able to argue that I did not accurately summarize the expressions or the reasons for the vote.

So I think that for the purposes that we're intending this summary to serve, we're simply going to have to live with a longer time line, that it will have to be a week or more than a week, at least until the transcript is available, so that we can have the document that will meet the needs that we've set forth.

DR. HILL: For our purposes, we're going to have to take some responsibility in the questions that we ask the panel because what we need more than why you voted like you did is what your scientific reasoning is. So the points at which there's consensus of the panel and the

recommendations, that's going to be most helpful to us, not so much the details of the dissent, but the whys. And I think we can get at that with the questions.

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So Sharon's two-step process, we can go ahead and fulfill our obligations under the federal law with a summary. And do you want to set a time frame today for how long you expect the panel to turn it around?

And one last question, if I may. May I take it that the Executive Committee is telling the panels that if the chairman of the panel disagrees as an individual with the findings of his or her panel, that they are tasked with writing or cooperating in the writing of the summary in the most favorable possible way against their own call, but in keeping with their panel's decision, rather than delegating?

DR. SOX: Well, that was my opinion, but others may disagree. I just think we're professionals, and we ought to be able to do that.

Jeff, can you give us a signal? Your voice is saying, and your face is saying, you're not sure whether a week or the same day is really going to serve us well.

DR. KANG: I'm not sure I understand the recommendation that's on the table or on the floor or whatever. I guess what I'm hearing is a

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summary that discharges our responsibility under FACA, but then a formal, kind of, more thought-out, well-reasoned document following it?

DR. SOX: Maybe we can do two things.

DR. HILL: I'm suggesting that in most cases I think we're going to be able to go ahead and use the committee's recommendations on the basis of the preliminary thing, and if people want to get their statement on the record for the record, to further the record later on, I don't think we're going to have to wait.

DR. HOLOHAN: I think you've just

confused me. You can make your decision on the basis of want while waiting for a more formal explanation, which makes it seem like the explanation is ipso facto redundant.

DR. HILL: No, sir. I'm sorry. I didn't mean to say that. Thank you for pointing that out. I mean to suggest that we can begin the process of working with the results of the panel's findings, getting it into a form that we can use. We don't sit down the next day and say okay, that was it, here's the decision, and issue it. We've got to go through some more work with it ourselves. So if you take ten days, it's not

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going to slow us down. We're going to begin our work right away.

DR. BROOK: Can I just make a suggestion here? We have three things on the table. Maybe we're just going too far. There's to be a vote at the end of this. There's this transcript. Sharon said that HCFA has to write a summary of it. Maybe we just ought to leave it at that and allow panelists the opportunity to submit within a couple of days any justification for their vote, if they so choose. And then we get away from the chair having to summarize opinion without voting and doing all this kind of stuff. But basically that they will have a vote on the issue.

They're already going to have a summary of the transcript that HCFA has to prepare and which presumably is going to be done technically competently. That will leave us with only the option that a panelist could offer, if they would like to explain their vote in writing, they could do it or not do it.

DR. SOX: The problem with leaving it as an option is that --

DR. BROOK: Then you come back to the

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answer that you require each -- I don't see how you can avoid requiring each panelist within a reasonable time period -- doesn't affect the

vote -- to add anything else they want to add to the record. That's what you're asking them to do.

DR. SOX: I think giving each panel member the opportunity or the obligation to say why they voted is going to help HCFA to --

DR. BROOK: So the panelists either orally or in writing will be given the opportunity, both orally or in writing, to indicate why they voted on a particular issue. And that discharges their responsibility. And the panel chair's responsibility is to arrive at a vote on this subject, not to write the summary. And it's HCFA's responsibility, going over the transcript under whatever this law is, to basically write the summary. And then we don't have a lot of redundancy.

And I don't think any chair, believe it or not, is going to spend the next two days after getting the transcript reading the -- it takes two days to read it, right -- to read through the transcript to summarize it while HCFA is doing the same thing. That doesn't seem to make a lot

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of sense.

DR. SOX: Alan?

DR. GARBER: Well, I want a stab at this. I think a lot of this discussion is based on some unstated assumptions maybe I don't share. I think unlike the two panels that met already, the way the future recommendations in this report are implemented, it will be a highly structured evidence review. The issues the panel will have to deal with will be very sharply focused. The staff has done its job in preparing these reports. And it will boil down to a limited number of issues that the panel will have to make decisions about.

And frankly, I don't think it's that difficult to write a brief summary in real time that talks about those issues. It does not mean that you redo the work of HCFA staff as part of the report. And I have the sense that people are talking about a very extensive redredging of the

information and the arguments and so on, and I would suspect that will almost never be necessary if a good evidence report structured on the guidelines that this document states is available.

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I think this is actually pretty simple. We're talking about what might amount to a handful of bullet points, to summarize it. And I think a longer report, given all the other materials will be issued, is not going to be particularly useful.

DR. SOX: Maybe what we should do is to require a brief summary and then leave it up to the chair, if he or she wishes, to write something that would be somewhat longer, that would be literate, logical and so forth, and then just see what happens, what feels right once he or she has some experience with that.

DR. HOLOHAN: One of the purposes of this is to get uniformity and consistency, and it sounds like we're now drifting away from that again.

DR. SOX: But on the other hand, we're in a mode of trying to learn by doing. And if we have an understanding that we're going to reach some final decision on this in a year, then we can have our cake and eat it too.

DR. MAVES: I actually support Bob's opinion on this. And I think if you do want to write a summary, if the chair wants to do it, I

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think it would be fine as long as it was contemporaneously done, as Alan has indicated. I'd be very concerned about a report written a day or two after. You sort of go home on the airplane, you think about this, you do the inevitable Monday-morning quarterbacking, and the report that Sharon writes and the report that the chair writes may have a little different spin or a little different angle. Not much. But that could be very, very important as time goes on.

So I agree with Bob. I think we've got

two or three sort of summaries. You have a transcript. You have a HCFA-put-together summary of the meeting. You have the testimony of the individual panel members as they give their votes on each one of these things. I think that record should stand as is, and I think to do otherwise, except for perhaps a contemporaneously written document by the chair that's there, that we can see, that we can look at just like this, I would be very, very concerned about both panel members and the chair writing something after the fact that would potentially cause us more problems than fix them.

DR. SOX: It's pretty clear we're not

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going to reach a consensus on this, so I think we should have a motion and have a vote and move on. Anybody want to make a motion so we can get off this one? Mike, please.

DR. MAVES: I would move that the deliberative process that we use consists of the transcript, which is already being done by HCFA, the summary, which will be prepared by HCFA staff, the oral comments of the panel members as they testify, and that those three pieces of evidence suffice as the work product of the panelists.

DR. JOHNSON: Second.

DR. SOX: Any discussion of that motion?

DR. KANG: I have a modification.

DR. SOX: Please. A friendly amendment?

DR. KANG: A friendly amendment. I think what we want here is a summary, we want the transcript, and then we want the opportunity for dissent or whatever, which could always occur later.

The summary could be done either way. I would suggest it could either be a HCFA-done with, as I understand, FACA, with agreement with the chair, or they can go ahead and do it right

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there and leave it up to the panel to figure it out. But the end result is the summary, either

HCFA-done, with approval of the chair, or Alan, kind of contemporaneously with whoever is doing it right there at the panel, the transcript, and then finally an opportunity for written further dissent, comments or whatever.

DR. DAVIS: And a vote tally.

DR. KANG: And a vote tally.

DR. SOX: Michael, is that acceptable?

DR. MAVES: I'll accept that.

DR. SOX: Okay. Do we second it? Any other comments?

DR. FERGUSON: Wait a second. So let me understand this. So this summary then, instead of being written by the chair, will be either written by HCFA and/or with the chair's input?

DR. KANG: The way FACA runs is by HCFA with approval of the chair. So essentially the chair is delegated to represent the whole committee, or in fact, given the tone and everything, they can just go ahead and write it right there.

DR. FERGUSON: Done at the end of the

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meeting so that it's seen by all those present at the meeting; is that correct?

DR. KANG: Right. Either one. Up to the chair. Either way would be acceptable.

DR. SOX: It wouldn't have to be done at the meeting.

DR. KANG: Right.

DR. FERGUSON: So that this third thing on our proposal here is sort of nixed at this point? 3. Explanation: A panel must explain its conclusions in writing. We're now doing this --

DR. SOX: We've now operationalized that. We probably should add this to the document, add Mike's motion to the end of this just to make it operational.

DR. FERGUSON: The transcript is done anyway. That's a given.

DR. KANG: Right.

DR. SOX: Ready to vote? Bob?
DR. MURRAY: I would just like to make a comment. I'm inclined to vote against the motion. The reason is that when we had our executive meeting in December, I believe we got all of the documents that were discussed. We had
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the HCFA summary of what had happened at the previous two panel meetings, and we had voluminous information. But in all of that, what I found most valuable was Tom's summary of his view. And what I hear happening is that we would not ordinarily get that unless somebody like Tom chose to do that.
I would rather see a reasoned summary done after the fact because that would make our job as an Executive Committee much easier and I think more effective.
DR. SOX: Other comments?
DR. BROOK: There are two ways of writing a summary. You've now recalled my memory. I believe the HCFA summary was day one began with this. These people testified. That's not a summary.
When Sharon said that HCFA is required to write a summary, I understood that to be an executive summary of the 400 pages like the chair did up to now, which says here's the evidence, here's the major evidence discussed, here's the opinions, and here's the results, and that the panel would actually look at this 20-page executive summary of these 400 pages of material
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or maybe 30 pages of these 400 pages and have that kind of a document. But if that's not the case, then somebody has to write that document.
MS. LAPPALAINEN: But the summary must reflect the agenda and what happened that day, so the construction of the last three summaries, which should have been available -- as a matter of fact, we have one as a public handout now -- followed the agenda of December 8th.
DR. BROOK: But it didn't have any

summary of the issues. It did not have anything that said the scientific evidence was presented. The panelists basically looked at it. The scientific consisted of this kind of information. In other words, it wasn't a contents summary. It was a process summary.

And I agree with you. Somebody should write for the record a 20-page or so contents summary of this voluminous amount of material that only a very few people are going to read.

DR. GARBER: That's the evidence report. I think looking back on the last panel meeting, this is a misleading -- because we will have evidence reports in place. That is assuming that the recommendation goes forward. So a lot

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of this would be superfluous.

DR. KANG: I think that's absolutely correct. We can't look at the last two meetings as -- these are all interactive. The reality is the first half of this discussion was setting guidance. It's saying that these are the questions they'd have to answer. Then the fact that -- good evidence report, this really tees up the issues, and I think that we're learning, quite frankly, as we're going along, and I really don't think that the first two will be representative of --

DR. SOX: I think we have a motion on the table. We've had some discussion. Is there anybody else who would like to offer discussion before we vote?

DR. FERGUSON: I guess my discussion is a question again. The last sentence here, the panel chair is responsible for writing the explanation of the panel's conclusions, modified with what Dr. Davis did, that's different than a summary, as Dr. Brook said. So we're not voting on whether or not the panel chair or a designee should write a summary of the panel's conclusions. We're voting on something else.

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DR. SOX: Why don't we vote on this,

and then it seems to me that vote implies we ought to cross that out.

DR. KANG: How about the panel chair is responsible for writing the executive summary?

DR. SOX: But according to the motion, apparently not approved, it could be the panel chair or it could be HCFA staff with the panel chair.

DR. KANG: So HCFA staff or panel chair.

DR. SOX: I think we can basically delete that sentence and substitute the process that we voted on.

DR. FERGUSON: Delete this last sentence? Is that what you're saying?

DR. SOX: That would be implied if we vote this in. Any other questions?

DR. HOLOHAN: Can I ask for a restatement of the motion?

DR. SOX: Restatement of the motion, please.

DR. MAVES: I'll try. The motion was that the operational documents that would result from the panel meetings would be -- the transcript will be number one.

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DR. SOX: Not quite so fast.

MS. LAPPALAINEN: Operational documents.

DR. MAVES: From the panel meetings would be the transcript of the meeting, the summary of the meeting -- and I think you could put in parentheses prepared by HCFA staff -- and the explanation of each member's votes for the deliberations or the questions that are asked by folks.

MS. LAPPALAINEN: With an opportunity for dissension?

DR. MAVES: With an opportunity for dissension.

DR. DAVIS: If I could ask a question. If there are seven questions posed to the panel, then you'll have to go around the table and get an explanation from every panel member for each

of the seven questions?
DR. MAVES: Yes. And I think that mirrors the practice that goes on at the FDA, if any of you have been out there.
MS. LAPPALAINEN: As I have it written, operational documents from the panel meeting will consist of the transcripts, the summary that is
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prepared by HCFA and signed off by the panel chair, an explanation of each panel member's votes with an opportunity for panel member dissension.
DR. MAVES: Yes. I want to make sure my seconder is here. Jeff, you're comfortable with that?
DR. KANG: John, you were about to say something.
DR. FERGUSON: I'm not sure that's different than what we did before. I mean we went around and voted on each question, and we were obliged to say why we voted against something, not really obliged for why we voted for, and that was all captured in the transcript and then HCFA's summary.
DR. MAVES: The reason for this is my sense was that we're getting to a point where we're going to have a third document, which would be the chair or his designee's interpretation being done at some point afterwards. And my key concern about that was that you could have two different, if you will, interpretations of the same meeting. And rather than that we have this as much as possible, either contemporaneously
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recorded and transcribed or as needs be done apparently through FACA, the HCFA summary of the meeting done as well so that we don't have situations -- and I think we had a little bit of that last time where the interpretation of the meeting and the HCFA document and the chair's recommendation or the chair's interpretation of the summary were two different things.
DR. SOX: I think there was one more

comment.
DR. BROOK: I want to just be clear about the HCFA thing. Sharon, when you write the HCFA summary, the last part of this is you're going to have the up-front evidence report, then you're going to have the explanation of the votes. So you're going to look at this, the two pieces of this stuff. Other than the process of the agenda, you're going to summarize something from the evidence report, a summary of the evidence report, what's available going in, and then the common themes across those whatever number of panel votes for each of those votes.
So if Alan said the reason I voted yes on this was because there were six controlled trials and seven of these, the benefit was this,
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and I believe it could be extended, you're going to look at how they come across all the individual panelists and then summarize that in a factual manner so that it would be an aggregated factual summary across the vote. That's the key of what would have to happen. It would be factual, but the aggregate across the votes is based on reading the transcripts.
Is that what I understand this summary is going to be? If everyone has agreed or said the same thing, it could be one page?
MS. LAPPALAINEN: Right. The requirement for this motion -- and that is an explanation of each member's votes -- will be added to the agenda as an agenda item for each panel, and that will be included in the summary if that is a required agenda item for each panel.
DR. BROOK: There are two issues here. You have ten people each saying a paragraph of stuff. Somebody's going to look at the common themes and write a summary of that. That's the key fact that has to be done. And you're going to do that. HCFA's going to do that.
DR. SOX: And the chair is going to
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approve it.
DR. BROOK: Now, does the chair have a right, if they're nonvoting, to actually give his or her summary on the record when you go around? After you've taken the vote, can we modify the process so that the chair just doesn't sit there, let's say at the end of this or at some point in this process, and say here's how I would have voted or something like that and here's my explanation? Can that be done legally?
MS. LAPPALAINEN: Right. Presumably after the voting period on the agenda and the agenda item, which has been added, which is the explanation of the vote, this also includes at the end of that an opportunity for the chair to express his or her opinion after the vote.
DR. BROOK: Why don't we require that. Why don't we state that the chair should on the record, after the vote has been taken, explain his or her explanation for what he would have voted or she would have voted, if he had the opportunity to vote, so that it becomes part of the record and part of the summary that you write.
DR. SOX: Does that sound reasonable?

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DR. BROOK: So we don't get the problem with the chair saying something later because he or she never had the opportunity like happened last time.
DR. SOX: In just a minute Sharon's going to read the motion, but first, since there has not been a motion to vote, there's still an opportunity for people to comment if they wish to. Hearing none, Sharon?
DR. HOLOHAN: I don't want to redundantly overclarify, but the HCFA summary will in fact be what's written in this paragraph as a -- and I'm quoting -- written explanation?
DR. BROOK: Yes.
DR. HOLOHAN: Okay.
DR. SOX: Ready to vote? And you're going to reread it and then say who's eligible to

vote and who isn't.
MS. LAPPALAINEN: The motion which we have on the table -- and we have a second I believe -- is the operational documents from the panel meeting will be the transcripts, the HCFA summary, including an explanation, an explanation for each panel member's votes at the panel meeting, with an opportunity of dissension. The
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chair after the vote will provide their opinion.
DR. SOX: Ready to vote? All in favor?
DR. KANG: I think it's a summary of the votes. It's an aggregate explanation with an opportunity for dissension. The point is it's got to be a content summary. It's got to say we took a vote, here was 8 to 3, and on average this is why it went this way.
DR. BROOK: It could say in voting yes, that there were adequate controlled trials, three said there was this, and two said this, but you have to take that two paragraphs of that -- or that two minutes of what that person says and write a thoughtful summary. And we're giving the HCFA staff the responsibility to do that with the chair's approval, with the chair looking over that part of the transcript, which will be much shorter than the bigger thing, to do that.
MS. LAPPALAINEN: The motion is operational documents from the panel meeting will be the transcripts, the summary that HCFA prepares, including a summary of the content and explanation of each member's votes at the meeting, with an opportunity of dissension. The
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chair after the vote will provide their opinion as well.
For today's meeting the members that are eligible to vote on this motion are Thomas Holohan, Leslie Francis, John Ferguson, Robert Murray, Alan Garber, Michael Maves, Frank Papatheofanis, Ron Davis, Daisy Alford-Smith, Joe Johnson and Robert Brook.

Dr. Sox will vote in the case of a tie vote.

DR. SOX: All those who are in favor, please raise their hand and keep it up long enough for Sharon to tally the vote.

DR. SOX: Two against. Abstentions? One abstention.

MS. LAPPALAINEN: I'm going to read the vote back. For the motion we have eight for, two against and one abstention.

DR. BERGTHOLD: Now you need a written explanation of that.

DR. SOX: We now need to move on to talk about structure of the evidence provided to the panel.

DR. FERGUSON: We don't have to explain our no votes here?

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DR. HOLOHAN: I think you should be free to express why.

DR. SOX: Why did you vote no?

DR. FERGUSON: I voted no because of some confusion on my part as to the timing of when these documents will occur. My understanding is that the transcript doesn't occur to be finished until a week or more later. The summary before wasn't finished at the time of the meeting so that we could all look at it. And I can't imagine that summary occurring at the end of the meeting in a fashion that can be seen by all of us. So since I was not clear on when that could occur in a way that I could conceive of, I had to vote no.

DR. SOX: Ron, do you want to explain your abstention?

DR. DAVIS: I thought it was confusing and awkwardly written, and I liked the original with the amendment that I proposed.

DR. SOX: And Leslie, your no vote?

DR. FRANCIS: I would have preferred just the requirements in the Federal Advisory Committee Act and let panels explain it.

DR. SOX: Thank you very much.

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DR. HOLOHAN: Could I explain why I changed my vote? I thought that Bob Brook really nailed down the content, and I was comfortable with that.

DR. SOX: Does anybody else want to explain a positive vote? Hearing no other comments, let's move on to number 4, structure of evidence provided to the panels.

I guess before we get into this, I'd like to note that we have not at this point said what ought to go in those evidence reports. And presumably if we approve this section, then we're going to have to get a group to get together perhaps to work in collaboration with HCFA to decide what will be the requirements for whoever's going to write the evidence report. I think maybe that would be better to not try to do that together, but rather to do that off line since it's really in the area of operations.

If anybody disagrees with that, I'd like them to speak up, but that's my take on it given the time.

Alan, do you think that's reasonable to do it off line?

DR. BERGTHOLD: Mr. Chairman, it's

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2:35, and we had a break scheduled for 2:15. I just want to check. This next thing is going to be actually I think complicated, or maybe not.

MS. RICHNER: Yes.

DR. BERGTHOLD: So I was wondering could we take our break now?

DR. SOX: We're hard at work, and we've shown our ability to talk for quite awhile in trying to solve some of these operational issues. So my suggestion is if there are members of the panel who need to excuse themselves, they should do so, but I think we ought to just work straight on through.

Okay. So now we have number 4, structure of evidence provided to the panels. And what we're interested in hearing is -- again,

just to remind you of objections to this as a basis for the panel's operations or lack of clarity that's going to interfere with your ability to work with your panel. And if you have a problem with the language, we'd like you to propose a change so we'll have something specific to work on.

With that, I'll open the discussion. Jeff?

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DR. KANG: Could I just ask a question as to your opening question? Because I missed the first MCAC meeting of executive counsel.

I actually had thought the whole purpose of the preceding four or five pages, quite frankly, posed the evidence questions that the evidence may support needs to think about with this, so I was -- that was my -- and you're thinking now that that's not adequate?

DR. SOX: I guess for myself, I'm thinking that it provides the framework, but it will be my, for example, wanting to talk to the folks who are running the U.S. Preventive Services Task Force to find out what their charge has been to the evidence-based practice, for example, what their deliverables are, and then modify that as appropriate to meet the needs of this group. I really think we need to define the deliverables of whoever's going to provide these reports, and those are specific.

DR. KANG: Let me suggest a strategy because that second issue you raised is more of a logistical issue. It's an issue as to -- whatever we want exists already or can we get it -- I'm kind of wrestling with why it would be

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fund -- I know that it meets the -- but why wouldn't we want the evidence-based report to take the first stab at answering the questions that we have posed here in the heart of the first five pages of this document?

DR. SOX: We might have some opinions based upon our expertise about what they would

actually have to do to answer those questions operationally.

DR. KANG: But there you're trying to do deal with that in number 5. Whoever's working on the evidence-based report who wanted interaction with the panel members back and forth, these things could get created -- some interaction back and forth.

DR. SOX: Maybe it would be useful for Alan, who's at least peripherally involved in -- comment on what sort of things go into their report just so we have an idea of what we're really talking about.

DR. GARBER: I think actually if I can go to the prior question first, I think Jeff and Hal are talking about this real important operational issue, should the Executive Committee give a lot of detail about how the evidence

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should be structured to HCFA or should HCFA staff proceed. And my relevant experience is actually as chair of the med-surg panel where we've been going over the agenda for our upcoming meeting, and I've seen the first draft of what would be an evidence report, and it's occurred to me from seeing that, which I might add so far seems to be very well done, that we might want to build up some experience with HCFA staff doing these before we make recommendations.

So I actually think that what they've done so far is exactly the kind of thing that this committee would recommend anyway. And maybe because there are some areas that are a little different, like diagnostic technologies, we might want to gain some experience before we the Executive Committee make any more specific recommendations.

I'm actually very sympathetic to what Jeff has just said based on my experience in trying to prepare for our upcoming meeting. That is it may not be suitable for us at this point to give very detailed information about what things like evidence tables should look like because

right now what they're doing for the urinary
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incontinence studies is exactly what any EPC would do.

DR. KANG: Let me add. It's unfortunate because I don't think the first two issues are representative. Reality is we can contract out for some of this stuff, and we can have, whether it's the tech assessment group over at AHRQ or whatever, and then there's no reason why the panel member can't interact with whoever's doing that and interact in a fashion, take a quick look, say no, you forgot to ask this question or whatever.

I don't think we should get into the logistics of how to do this. I think we should just stick with we want an evidence-based report, here is the list of issues and concerns we are concerned about right now at this point, and start working to answer those questions, and then have number 5 there as an interaction to the extent that they're things that are coming up that we didn't anticipate.

MS. RICHNER: One of the discussions that we had in our conference call, if you'll remember correctly, was that the panels would have an opportunity to pose the questions for the
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evidence report before they were originally conceived. So is that still the issue? I mean that's still going to occur then?

DR. SOX: That will be number 5.

MS. RICHNER: My other problem and question once again, how does this fit? I still don't understand how and where the evidence report fits in this Medicare coverage process that has been published. So where and how is it triggered and where does it fit in terms of the panel receiving it? I still don't understand it.

DR. HILL: In that flow chart you'll see where we have the opportunity to refer things to the Medicare Coverage Advisory Committee when

we take in issues as part of the process of preparing the information for that committee between the time the intention is arrived at to send something to the panel and an accurate amount of time before the panel. So they can be able to digest it, we either create or get some help in creating this evidence table.

MS. RICHNER: So the evidence reports as we know take approximately six months to do.

DR. HILL: Not always. We've had

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indications from AHRQ that in some cases, many cases, they'll be able to do something for us a little faster than that. We're working on our own process internally trying to gear ourselves up to be able to do those things faster.

If you're concerned about the time frame that's involved, that's not stated on there, and it wasn't -- so this doesn't change that.

MS. RICHNER: You see, if we have the evidence reports being -- there has to be something written in here that when you, HCFA, trigger this to MCAC, the evidence report and the questions that need to go into the evidence report have to be decided by the panel at that particular moment. You have to have some mechanism for the panel to get together to say these are the seven things I want the evidence report to reflect, and that doesn't say that in here. I'm really grappling with this.

And then you have the six-month time period where the evidence report would be prepared approximately four to six months. Then it would come to MCAC. We would then get the evidence report and review it and have all this

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time associated with reviewing it. I mean I'm not tracking it with this document.

DR. SOX: Let me try to recall the end of my talk this morning. HCFA decides to refer something to MCAC. In that first month they work with the chair of the appropriate panel to define

the questions, and that's a process that could include other members of the panel if the chair so designated. And they decide who's going to do the piece of work and perhaps on the basis of the nature of the problem --

MS. RICHNER: Who's they decide?

DR. SOX: The chair and HCFA.

MS. RICHNER: Decide who it's going to be referred to?

DR. SOX: The decision about who's going to do it -- HCFA decision.

MS. RICHNER: Whether it's going to be ACRI or AHCPR or whoever is going to --

DR. HILL: Or internal.

DR. SOX: And then after that sort of month of preliminary work, whoever is going to do it gets the job, and they spend four to six months doing it. They produce a report. And then that goes out to the members of the panel to

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prepare for a meeting that will occur approximately a month after the report is completed.

MS. RICHNER: None of that is reflected in here. You know that, right? None of those times.

DR. HILL: That's correct. As I said earlier, we didn't state those times.

DR. SOX: Leslie?

DR. FRANCIS: This is a clarification question. As a member of the panel, I would want to get copies of the studies as well as the evidence report, right? I don't want to just get somebody's summary of it.

DR. GARBER: You may have 200 studies. Again this is patterned on well-established other technology evaluation processes.

And really, Randel, your questions are getting into point number 5. But anyway, the idea is that combination of staff and the chair will identify interested panel members with appropriate expertise and will involve them in the process of helping to advise HCFA staff about

the scope of the evidence report or advise the contractors or whoever it may be.

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And this is intended to make sure that the evidence report is the most suitable document for the panel's deliberations. That means not the entire panel is involved. The attempt is to bring in all the really interested members of the panel. And if by some chance that group of people -- that is, the chair and the interested panel is identified to assist in setting the parameters on the evidence review, if by chance they really goof up and they give directions that some important studies were neglected or the scope of it was wrong, that would come up during the panel meeting. And then perhaps the panel will conclude they didn't have the evidence they needed.

But generally speaking, this kind of system works where you get all the interested parties to give input early in the process, and you don't have to go through actually convening two panel meetings, one to set up the evidence report and another to evaluate it.

DR. SOX: Leslie?

DR. FRANCIS: I'm not asking for two panel meetings. I just would not feel, as a panel member, that I was in a position to

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evaluate the evidence unless I both had the studies on which the evidence report is based and the evidence report as an analytic summary of those studies. What concerned me with the myeloma panel was that I had about 30 studies and nothing else.

DR. SOX: My take is that if an individual panel member wanted those studies and had the time to do it, they could get them and that the evidence report, if it focused on two or three really key studies, that those might be included as an appendix to the report so you could read it.

DR. HILL: Our intention at this point

is when we identify, or the panel chairman identifies, key studies that should be sent to all panel members, they will be. And when you get to the table, if there's something you read off there, then we'll send it to you. And if you tell us ahead of time that you're the one person who wants to get the whole five crates, we'll talk about it.

DR. SOX: Any other comments about this section before we move on? Jeff?

DR. KANG: I had to step out of the

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room, but I wanted to comment to Randel's issues on timing. I said this earlier in the morning.

The last slide we had, which was some time frames, was actually -- I don't know how to say -- was kind of Medicare Coverage Advisory Committee centric I guess. The reality is that staff is really responsible for the logistics of the timing and the flow.

I really would encourage you all in your deliberations to consider what is desirable, what do you want. We then are responsible for the timing and the logistics and meeting what we said we were going to meet in the federal register notes. And we're committed to trying to make that work.

Now, it may turn out what you all believe is desirable is physically humanly impossible, and then we may have to rethink this. But I actually, quite frankly, think it is possible. And this guidance that you've given staff is extraordinarily helpful because it will lead quickly to evidence-based reports to answer the questions or up front there's this interaction in step number 5. I think this is very doable and still meeting the time frames

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that we said in the federal register notes. That's a commitment. But our issue is to try to sort out the logistics, and we will do that.

MS. RICHNER: One more question. The data. There was a point when we had our

orientation for the panel members. As an industry representative, anyone can give me information that I would share then with the panelists. That's one of my roles, which could be unpublished literature, it could be white papers, it could be FDA information, that would not have been provided in the evidence report.

Where and how does that get considered? I know that they may not be controlled studies, but it's information that can go into the decision-making process. So where does that fit?

MS. LAPPALAINEN: Right. The industry representative's role on the panel is to represent industry. And if you believe that information needs to get to the panel, you need to give that to us at HCFA, not directly go to the panel and have the panel interact.

MS. RICHNER: But how does that fit into this? Is it the only thing you receive is

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the evidence report?

DR. KANG: It's part of the evidence report.

MS. RICHNER: So that means I would have to give it to ACRI or AHCPR?

DR. KANG: You'll give it to us, and we'll figure it out.

DR. BROOK: The only problem with that is if the information is proprietary, then you're going to have a hard time because the evidence report, you're job should be -- everybody's job should be to get to the person at HCFA everything under the sun. And that person should summarize that in an unbiased manner. And so published, not published, we ought to be beating every drum we can find to get good information. But if you send along a tag you can't use it or publish it because it's proprietary, then it won't be used.

MS. RICHNER: Of course.

DR. KANG: Randel, it's really not your responsibility. It is the requester's responsibility.

MS. RICHNER: Right. But it's not reflected here in this process, and so I just wanted to make sure that -- maybe the public now
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is aware that that is part of the process, that information can be provided to your industry or consumer representative that should be given to the panel or to HCFA as part of the evidence report.

DR. KANG: We'll make that clear, but I don't think this is the document to make it clear.

DR. HILL: We already do invite those sendings in our announcements.

DR. SOX: Any other comments on this section before we move on?

The next section is about panel member involvement, the chair up front with appropriate other members of the panel, in framing the questions, and several panel members should be participants in the evidence review as a way of gaining familiarity with data and expertise on the topic, and finally, there should be a couple of primary reviewers whose responsibility would be to spend a lot of time going over the evidence report prior to the meeting and be in a position to summarize their take on the evidence as reflected in the report.

So those three aspects of panel member
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involvement are now open for discussion.

DR. HOLOHAN: I think I'm asking this for Leslie. It says panel members should take an active role in reviewing the evidence, a word that I believe is distinct from the evidence report.

DR. FRANCIS: It's not the evidence report. It's the evidence.

DR. GARBER: I don't think that's realistic in some of these areas; that is to say to review all the evidence. I mean this is basically reviewing all the evidence. You do a serious job of it even without writing it up.

It's a several-week, full-time job.
DR. HOLOHAN: I understand that. I'm simply saying it --
DR. GARBER: Oh, okay.
DR. SOX: What do you think would be good language there? Reviewing the evidence report?
DR. KANG: Preparing the evidence report.
DR. SOX: So it would be an active role in preparing the evidence report?
DR. FRANCIS: The reason I had made

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that is not equal to the evidence is I'm not going to know how to vote as a panel member unless I think I've been able independently to come to my own judgment. I'm not around here to rubber stamp an evidence report. An evidence report and other people's comments on it are helpful to me in trying to reach my own judgment, but if it's all just laid out and I can't in any way try to exercise my own critical judgment, I don't have any business being here.
DR. BROOK: First of all, there's no rubber stamp on this. An evidence report just puts the evidence together. And then you need to produce the judgment, based on the evidence, what to do.
Now, if you're saying you want to redo the evidence report, what I think Alan and I are doing, having done a lot of these evidence reports, be it as it may, in areas which have lots of literature, we've reviewed 10,000 titles to come up with 300 articles to summarize, and we're struggling to get this done in six months.
There is no question that HCFA, if you'd like, should be able to provide you all the original material that we work from, but I will

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tell you that unless you're the most extraordinary individual under the sun, you will not have the time to redo this what to do, but you ought to have the right to do it.

And certainly I think any panel member ought to have the right to get the original evidence, and it ought to be stored in a manner, put together in a manner, and that ought to be sent out. But you ought not to expect the average panel member to do that. We ought to expect the average panel member to believe that the evidence has been synthesized correctly, and now you have to make a judgment about how it should be used and what it means.

DR. SOX: Do you want to add to that?

DR. GARBER: I think Hugh put it really well about how this would work. I think, Leslie, the issue for us is going to be we have to look at the original data for some key studies, and all the panelists should get those key studies, but not the huge volume that Bob was alluding to that we usually start with. So that's why this will never be -- I doubt that this will ever be a rubber stamp. The panelists are going to read some studies, but they have to be whittled down

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somehow. And that's all we're saying is be selective about it.

DR. SOX: I'd like to hear from the panel if there's objections to the concepts that are imbedded in the boldface number 5. Does this look reasonable for panel members? That's great.

DR. BROOK: Under the first boldface it should insert report.

DR. SOX: Panel members should take an active role in, I thought we said, preparing the evidence report.

DR. KANG: Preparing the evidence report.

DR. SOX: Not reviewing. Change it to preparing and insert report after evidence.

So let's discuss this section trying to pick out -- we don't have a lot of time now, so we've got to kind of focus again on problems with clarity, pieces that are objectionable. John?

DR. FERGUSON: Just a suggestion. This

number 5 might better be put on one of the first under Suggestions for Panel Operations because this sort of explains what the beginning of the process is, which Randel was questioning about.

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Because this is the first part. The evidence report, the panel chair and others working with the evidence, we're going to do the evidence report. And the first thing you start out with is actually the end result.

MS. RICHNER: That would help a lot, just moving it to the first.

DR. SOX: The problem is that it does talk about the evidence report, which is defined in the immediately preceding section. It can certainly be --

DR. FERGUSON: It sort of operationally comes after the fact.

DR. SOX: I think we can probably move the first one till later because it comes later in sequence. That would work. Okay.

Other comments on this section? In that case we're going to move on to number 6.

MS. RICHNER: One more thing. To me, once again, it's the timing, but that's going to be clarified by HCFA and not by us?

DR. KANG: We're on the hook for timing.

DR. HOLOHAN: If I can offer an unsolicited comment. There's been a lot of

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concerns first about how long these take. If nothing else, the experience with the first two panels should have instructed us that doing it the right way is the fastest way.

DR. SOX: Just to quickly follow up on John's suggestion, consistent with John's suggestion that we try to get these operational things consistent with sequence, everybody happy with moving the first one, which is now number 3, a panel must explain its conclusions in writing, make that the last one? Okay.

Then let's move on to number 6, which

is expert review of evidence reports.
DR. KANG: Before we discuss this, can I ask the subcommittee to explain why this is here just so I can understand?
DR. SOX: The opinion of experts is the best way to assure everyone that the evidence report is complete and fair. So it's a notion getting said people that are competent experts to look at it and say it didn't miss anything, the report didn't distort the clinical facts as we know it. It's something that, at least on all the other panels I've been involved with, outside review has been a key part of it if only to
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establish the credibility of the process, to say look, we've given the people who have an axe to grind the chance to sling their strongest arrows.
DR. KANG: Well, maybe I didn't read this closely enough. The assumption here that the evidence-based reports are being done by nephrologists, internists or whatever and that the final analysis, if it's about some surgical procedure, that you'd also like to show it to a couple of surgeons? Is that the issue here?
DR. SOX: That strategy -- namely, having evidence-based clinicians prepare the report, then have it reviewed by competent experts -- seems to really work well on the other side.
DR. GARBER: Jeff, one of the explicit precedents here is the evidence-based practice center's review process in which the external reviews come from actually a wide range of types of expertise ranging from pure methodology to pure clinicians. I'd just like to emphasize the language here is committee recommends expert review. I think we recognize this could be onerous in some circumstances and maybe not always is necessary in some circumstances as
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others. So this is really truly advisory, but we do feel it's very important to do it to ensure the highest quality.

DR. SOX: Any other comments about this section?

DR. FRANCIS: I apologize for continuing to beat what's probably a dead horse, but I really do think whatever else you do, in addition to the evidence report, you ensure that panel members have the key studies. It's okay from the evidence report to identify key studies, but I want to see them too.

DR. SOX: Ron?

DR. DAVIS: I actually scribbled out a sentence to address that, and if the Executive Committee feels it's important to make that explicit, panel members will have the evidence report at their disposal and will have the right to obtain any primary sources upon which it's based. But I don't think there should be an affirmative obligation on behalf of HCFA staff to send us all those primary resources.

DR. SOX: That suggestion seems consistent with the discussion we've had. Any objections to it? Okay. Then we have to go back

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and --

DR. KANG: I'm sorry. I heard what Leslie was saying was key articles be part of the report and then that she also has access to the 10,000 if she wants.

DR. FRANCIS: Exactly. That's what I want.

DR. SOX: We've gone through the document once. Now, let's start over.

Ron has been given responsibility for marking up the transparency that Jeff and Leslie prepared during lunch. Do you have a report to make?

DR. DAVIS: It's over there on the transparency.

DR. SOX: Okay. Let's look at it and see if we like it.

DR. DAVIS: I tried to cut down words. The first line and a half goes in italics, I guess, because it's a subheading. Should I read

it now?
DR. SOX: Yeah.
DR. DAVIS: Medicare beneficiaries include elderly, nonelderly and disabled people. The Medicare population also may or may not
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include patients with comorbid disease. Historically many controlled trials unfortunately exclude older men and women, people with disabilities and people with comorbid disease. Thus these studies may have had adequate statistical power for the study population, but the results may or may not be generalizable to some portions or all of the Medicare population. If the requester is asking for coverage or if the panel believes there is a medical benefit beyond the clinical and demographic characteristics of the study population, the panel should state whether it believes the results of the studies are applicable to some groups covered by Medicare, define what those groups are, and explain its reasoning.
DR. SOX: Anybody have any changes they'd like to make to that masterful piece of rewriting?
DR. FRANCIS: Thank you.
DR. SOX: Great. Thank you very much, Ron.
DR. DAVIS: Alan just suggested at the end to change it to say define the groups, and then we'll say --
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DR. SOX: Daisy, are you ready with some suggestive language for the preface regarding --
DR. SMITH: Yes. In fact, if you'll recall, initially we had discussed the possibility of inserting it under external validity. And at that time when I was in that mindset, I thought we were going to say although the panel recognizes that adequate representation of every study may not be possible, consideration should be given to the applicability including

race and culture when appropriate and necessary. Then I thought that would get into too much, but that's what I was charged to do in terms of the insertion.

But instead I chose to suggest that we put it in the preface and add it to the amendment that had already been added, which stated so that Medicare beneficiaries -- you know, we said something about that. I think Linda started. Then I just added to that -- can be better served regardless of race, ethnicity or socioeconomic status. And that's a generalized statement without attempting an insert with limitations.

DR. SOX: Any objections to the way

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this is done? Then we have one more suggested change.

DR. BERGTHOLD: Mr. Chairman, when will these changes be on the books? I didn't take down every one. Maybe I should be asking Sharon.

DR. HILL: By next week. Maybe even sooner.

DR. SOX: So Ron, what is it that he just gave you?

DR. DAVIS: It's the sentence that I mentioned earlier about having the opportunity to review any of the primary sources upon which the evidence report is based.

DR. SOX: I'd like to move on now. I think we're ready, are we not, Sharon, to have open public comments before we vote?

DR. KANG: I actually have one modification, that we put in a phrase that says based on feedback from the panels, this is a living document basically. This has been modified. I just wanted to say maybe it's feedback from the panels and other stakeholders. Obviously we have public comment period. So it really is maybe the other way to say feedback from everyone. It could come from public, could

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come from the advisory committee, the Executive Committee itself.

DR. SOX: Do you recall where that language was?

DR. KANG: It would be the last paragraph before Evaluation of Evidence, the section that begins Evaluation of Evidence.

DR. SOX: We're running out of time because some of our members are going to have to leave at 3:30, and I'd like, if possible, to have as many people here for the vote on this. So we will put your suggestion in, Jeff. Sounded like everybody was happy with it.

We now have a 15-minute period when anybody who wishes to make a comment may do so. In order to assure that there be equitable distribution of the 15 minutes, I'd like anybody who wishes to make a comment to please raise their hand so I'll know how many people want to make a comment, and then I can decide how much time each person will be allotted.

In the event that only a few people want to make a comment, I would hope that they could keep their remarks short because we would like to have a whole committee here if possible

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for final vote on this document.

DR. KANG: I apologize. Just one procedural issue. You recall earlier this morning I actually gave up some time to try to get on with the meeting. I have an announcement I'd like to make with regard to coverage criteria for the public, and unfortunately I think the appropriate time would be right after the vote. I just wanted to alert people that I did want us to have maybe some closing remarks.

DR. SOX: Excellent. We look forward to those.

So Mr. Northrup is one person who's scheduled.

Anybody else who wants to make a comment? A total of four. Three minutes each.

Mr. Northrup?

MR. NORTHRUP: I want to thank you for this opportunity. This is about as close to the

last word as anybody outside the government ever gets on a public policy issue, so thank you very much. I do want to thank all of you for what you are doing for Medicare beneficiaries, and that's why we're all here. Before you close, I do want to also reiterate why what you're doing and why

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you're doing it --

DR. SOX: Excuse me. I didn't introduce you.

MR. NORTHRUP: I'm Steve Northrup, Executive Director of the Medical Device Manufacturers Association in Washington, D.C.

Again, I want to point out why what you're doing and how you do it is so important to the medical devices community and the patients we're trying to serve.

A way of a little background, our association, MDMA, was created in 1992 by a group of medical technology entrepreneurs to represent and serve medical technology entrepreneurs. And I do want this committee to keep in mind, and you probably already know it, but please keep in mind the foundation of innovation in medical technology is the entrepreneurial sector. Most of the innovation in this industry comes from entrepreneurs, and in fact, I read recently one of the CEOs of a large medical technology company said that 60 percent of all the medical products sold in this country are less than 12 months old. And that seems like an impossible number, but that's the nature of innovation in this industry.

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It's incremental innovation fostered by entrepreneurs, entrepreneurs with lots of ideas, but limited time and limited cash. And we need to be sensitive to that, and we talk about the type and amount of evidence HCFA's going to require and this committee is going to require and the amount of time it's going to take to reach a decision.

And that brings me to the points I'd like to make briefly about evidence and about

time. With respect to evidence, I do appreciate the steps you've taken today to make some of these guidelines, I think, more reasonable with respect to evidence. And ultimately HCFA's coverage criteria, which Dr. Kang will talk about, will provide that, quote, unquote, road map that manufacturers are looking for.

Manufacturers are willing to jump over a reasonable bar, but if it's unreasonably high where we can't even see it, a lot of us smack our heads right into it. And most importantly for your purposes, please keep in mind that most of the advances in medical technology that your panels will be considering are incremental advances and don't necessarily require a de novo

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review. So when you're looking at incremental advances, let's look at the incremental evidence.

With respect to time, still somewhat concerned -- and I do appreciate Dr. Kang's comments along these lines -- that some of the things you're considering will slow down the process of coverage decision making unnecessarily, and that will in turn slow down the pace of innovation in our industry. The government will never be able to keep up with the pace of innovation in this or any other industry. That's just the nature of the beast. But we need to try to keep the gap between innovation and the government's pace as small as possible. And with respect to the comment that was made earlier about doing it the right way is the fastest way, to borrow a phrase, I'd like to say it depends on what your definition of right is, and we need to focus on doing it the best way.

I do want to thank you for your time, and ultimately I'm not asking you to be sensitive to our companies or their needs or how they conduct their business. That's my job and not yours. What I would ask you to do is make sure

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that your actions and decisions don't hinder or

discourage medical technology entrepreneurs from innovating because innovation is the key to improving the health of Medicare beneficiaries. Thank you.

DR. SOX: Thank you very much, Mr. Northrup. Who's going to speak next? Yes, sir. Please introduce yourself.

MR. COOK: My name is Ken Cook.

MS. LAPPALAINEN: Do you have any financial interest in any service?

MR. COOK: I have no financial interest. My name is Ken Cook, and I'm a facilitator for a cancer support group at the University of Maryland Medical Center. I just want to make a comment on two issues on the external validity issue and Medicare patient participation.

Not only are Medicare patients excluded sometimes from clinical trials because of age, but because also of the financial problem. Since Medicare will not pay for experimental protocols and since probably most patients or most beneficiaries of Medicare do not carry separate insurance, unless they are financially

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independent, they're basically precluded from being in the population that is undergoing a clinical trial. So it's a catch 22. You can't get into the clinical trials because you don't have the money. That's the first item. And so I would like to point that out for your consideration.

The second issue is on the number of patients involved in any disease study. If you are studying prostate cancer, there are many, many patients available for clinical trials. There is sufficient research money available. But if you are a patient with let's say multiple myeloma, which is less than one percent of the population, there is very little research and very little research money available or public interest in that issue. And to try to require the same degree of rigidity in proof and making

sure that the protocols are as perfect as can be possible may not be appropriate.

So like there is the orphan drug law, I think that as we consider the various types of protocols and how they're applicable to the different groups, the same measures are not applicable to all. One size does not fit all.

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Thank you ever so much.

DR. SOX: Thank you very much, sir.

DR. KANG: Chairman Sox, could I just respond to the first point? I think that's a real issue. I'm very aware of the IOM report. I just wanted to say that I don't think this is the venue, the MCAC, but I just want to assure you that the issue on payment for -- clinical trials is very much on our screen and being reviewed here at HCFA.

MR. MESKAN: I'm Tom Meskan, Medical Alley. The committee at one point was discussing its willingness to take comments about tone and/or substance of the document, and I tried to listen to the conversation closely, but never heard a complete resolution of whether you wanted to accept those remarks that would have any value, and what's your orientation for us.

DR. SOX: I think the sense of the group is that when we put this thing back on the website in its modified version, it will call for public comment very much on the spirit that Dr. Brook suggested of specific wording that we might change, specific changes in the wording that might improve the tone. And it will, of course,

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be up to the committee to decide to accept those suggestions. But I think that's the sense of the group.

MR. MESKAN: As it relates to tone, are you open to substantive changes or do you feel that where your document is now is kind of where it is and yes, it's an interim document that will be ongoing, but should we bother to spend the effort to make our points again in perhaps more

compelling ways on substance?
DR. SOX: I think it would probably serve our group and your ideas best if you came back to us with them as we reconsider the document on a periodic basis. Given the time, it probably isn't going to get the attention that maybe it deserves.
DR. KANG: I think I did hear Bob say though -- and I thought it was appropriate -- that substantive changes would be considered, but then you have to justify why the substantive changes should be in that item.
DR. SOX: We want suggestions about tone and substance, and we'll take them up in due time, but we won't ignore them.
The last speaker, please introduce
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yourself.
MR. LASCHER: Steve Lascher, epidemiologist of the Maryland College of Physicians. I have no financial affiliation.
DR. SOX: What organization?
MR. LASCHER: ACP-ASIM. Related to the overhead that was written related to the generalizability, I just wanted to mention that statistical power was mentioned, and perhaps in that respect it wasn't the appropriate term since statistical power relates to type two error, and perhaps you were thinking about sample size, and it might lead to some misunderstanding.
DR. SOX: Thank you. It's now time for the committee to take a vote. Sharon?
MS. LAPPALAINEN: At this time Dr. Sox would call for a motion, and he will be asking the voting members of the panel to vote concerning whether the report of the subcommittee should be ratified or ratified with modifications or not ratified.
For today's panel, a forum is present, and the voting are Dr. Thomas Holohan, Dr. Leslie Francis, Dr. John Ferguson, Dr. Robert Murray, Dr. Alan Garber, Dr. Michael Maves, Dr. Frank
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Papatheofanis, Dr. Ronald Davis, Dr. Daisy Alford-Smith and Dr. Joe Johnson. Dr. Robert Brook is absent.

The panel vote may take one of three forms, ratification with no other modifications, ratification upon condition, for example, resolution of some clearly identified deficiencies which have been cited by you or by the HCFA staff. Examples of deficiencies could include resolutions of some of the questions of wording or issues that you believe are necessary or you would like to see implemented.

If you believe that modifications are necessary, then your recommendation should address the following points; the reason or purpose for the modification and the information that's required to change it. And for nonratification, if you believe that the subcommittee report should not be ratified, we ask that you state for the record your reasons why the report should not be ratified and to identify those measures that should be taken in order for you to ratify it in your opinion. Thank you.

DR. SOX: Sharon, am I correct in

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saying that the only people that can participate in the discussion now are voting members?

MS. LAPPALAINEN: Yes.

DR. SOX: I've asked Ron to prepare a motion, and I'll read it on behalf of him. Then there can be a second, then there can be an opportunity for discussion, and then amendment.

Motion, that the Executive Committee approve the subcommittee's report and recommendations as amended and that the Executive Committee revisit the report and revise it as needed in response to comments from panel members and the public.

So that's now open for a second.

DR. GARBER: Second.

DR. SOX: Second?

DR. FERGUSON: Second.

DR. SOX: Is there a discussion or modification?

DR. FERGUSON: The only modification that I would recommend on that would be to state the document be as it's approved, that it be used as an interim document so that HCFA could move forward in their process, that it be used as an interim document, recognizing that it is dynamic.

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And I would suggest that with the comments that we're getting from the public and from the panel members, that as part of the two-day meeting that we have scheduled next, that we make this an agenda item to revisit, at least at some point during that two-day meeting, part of the comments on this document.

DR. SOX: Why don't we get the wording up there. And then it would be nice, if we could get the wording up there, then you can suggest how to --

DR. FERGUSON: It's essentially the same thing except that it would be approved as an interim document would be the only other addition with that and that we specifically make it revisited in the two-day meeting that's planned next.

DR. GARBER: I guess I have a question. I agree with everything you said, but I take Ron's wording as meaning that it's interim when he says it should be revised and revisited. Is that acceptable?

DR. FERGUSON: As long as that's understood, yes. I have no problem with the word interim not being in there as long as it's

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understood that HCFA's got something they can move forward with now as part of the process rather than having to wait.

DR. SOX: Would you like to say something to the effect of a new sentence perhaps that the panel shall consider possible revisions to the document at its next two-day meeting or something like that? Would that capture the

sense of what you'd like to have? That would make it -- to do it --

DR. FERGUSON: Sure.

DR. SOX: -- as an agenda item. I guess as the Executive Committee, right? That's offered as a friendly amendment, Ron?

DR. DAVIS: Accepted.

DR. SOX: Any other comments or additional amendments? It's now time for a vote.

All those who are in favor, please signify by raising your hand. Hold it up so the counter can tally the vote. It's unanimous.

MS. LAPPALAINEN: Except for an absentee.

DR. SOX: We're now going to turn to hear briefly from Jeff with some announcement and benediction or something like that.

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DR. KANG: Actually I believe these comments were made for the public and will be available outside. They were meant as opening, and they're closing now.

I would just, Chairman Sox, like the opportunity to reinforce and expand on HCFA's preface to the subcommittee's, which has now been the adopted subcommittee's recommendations as amended. If people have that preface in front of them, I'd actually like to refer to the third and fourth paragraphs and just for the record read them in. Actually now it's the current document below.

We view the current document or the voted-in document as a list of suggested topics that should be considered and addressed to assure full and consistent discussion of issues by the MCAC panels. HCFA itself will not view this report as a prescription of criteria by which we are to determine coverage or even an absolute standard by which we may judge the adequacy of evidence.

In short, this document is a list of suggested topics that the MCAC and its panel should consider and address in evaluating

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clinical evidence in rendering advice to HCFA. Based on the advice in the record, HCFA will make its coverage decision. We are confident that the MCAC and its process will be an enhancement, not a barrier -- the new document that you've all voted in -- not a barrier to the fair and open consideration HCFA will give to proposals for coverage.

In summary, I think that we are interested in how good is the clinical evidence, what does it say, and what conclusions can be drawn from it? And that's really what the evaluation of evidence is all about.

Furthermore, as I stated in the fifth paragraph of that preface, we are not interested in asking the MCAC for advice on cost issues. You are really the clinical scientific experts, and that's what we're seeking your advice on.

Finally, with regard to coverage criteria -- that's in the sixth paragraph here -- we are diligently working on publishing a coverage criteria to further explain and interpret what reasonable and necessary means in discriminating cover from noncoverage services.

I actually do want to point out today
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that today's effort deals with what is the evidence, what does it say and what conclusions can be drown from it, how we read it and how we interpret it. That is distinctly different from criteria.

Scientific evidence is in many ways the yardstick or the measuring stick while criteria is really how far you have to go, whether you have to go one foot or three feet or ten feet to get covered. The evidence really is the measuring stick or the yardstick.

To further the analogy to our current situation, HCFA could interpret in a rule that reasonable and necessary means many things. For example, we could interpret it as meaning just safety, we could interpret it that a service has

to be safe and effective, or we could interpret it as it has to be more effective, or we could interpret it as benefits must outweigh the risks, or it could be interpreted as being cost-effective, or we could interpret it as being cost-beneficial. And there are other variations of the theme.

The point here is irrespective of what we finally end up as criteria in the final rule,

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it should not change your work regarding what is good evidence, how do we read it, how do we interpret it, what does it say, and what conclusions can we draw from it? Thus, your work is distinctly separate from our coverage criteria and can certainly go on in the absence of the criteria. Of course, in the final analysis, today's work only guides your activity and your advice, and HCFA will be the final decision maker of what should be covered or not.

Now, I would like to take this opportunity to briefly update you with where we are on the coverage rule. On a personal note, to my chagrin, I've now figured out why the agency has struggled for over ten years to publish a rule. However, the good news is that we actually do have criteria in mind and a framework for how they would be applied. However, it does raise several operational and implementation questions.

Given what is at stake and the considerable interest in this rule, I am pleased to report that we are expecting to publish soon a notice of intent for rule making in advance of a proposed rule. In this notice we will share our

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current thinking and framework for coverage criteria, how it would work, and we would also raise some of the implementation questions that we are wrestling with internally. Such a notice will provide ample opportunity for the public and other stakeholders or all stakeholders to have adequate input and assist us in our deliberations

before we even propose a rule.

And on that, today is not about coverage criteria. I thought I'd take the opportunity to talk to you about coverage criteria. But I would like to thank the advisory committee, the Executive Committee, for all of your efforts today to deal with, in a consistent manner for all panels, how we read the evidence. And I assure you we're working diligently on the coverage criteria, and I believe that you are off to a great start with regard to how we read and interpret evidence.

DR. SOX: Thank you, Jeff.

Before we adjourn, for the record we had one absence. Dr. Brook had to leave a few minutes early. He left this note.

I am happy with the report. I would like to see the revised Section 6, signed Dr.

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Brook.

Is there anything else that we need to do before we adjourn?

MS. LAPPALAINEN: Just to conclude today's panel meeting, I'd like to remind you that the next meeting of the Executive Committee is tentatively scheduled for June 6th through 7th, the year 2000. Please call the HCFA advisory committee line at 1-877-449-5659, which is toll free, or for local calls, 410-786-9379, and specify the Medicare Coverage Advisory Committee, or you may check our website for up-to-date information. And again, I'd like to thank the committee.

DR. SOX: Before adjourning, I'd like to point out that copies of Dr. Kang's remarks are available on the table outside the door. We want to thank everybody on the panel for their hard work and the audience for their patience. Thank you.

(Whereupon, at 3:40 p.m. the meeting was concluded.)